



INSURANCE RELEASE/AUTHORIZATION FORM

DATE: _____

TO: _____

_____ ATTN: _____

FROM: _____

NAME DATE OF BIRTH

POLICY NUMBER CITY

ADDRESS STATE/ZIP

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH FORMSCOPE, LTD. ANY RECORDS, REPORTS, AND ANY OTHER INFORMATION CONCERNING MY INSURANCE AND ALL FAMILY MEMBERS COVERED UNDER MY PLAN. PLEASE MAIL A COPY OF MY INSURANCE EXPLANATIONS OF BENEFITS FROM _____ 20 _____ TO _____ 20 _____.

I AM WILLING THAT A PHOTOSTAT OF THIS AUTHORIZATION BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

SIGNED DATE OF SIGNATURE

By my signature above, I acknowledge the release of any Protected Health Information (PHI) to the individual(s) designated on this release form. This protected health information is to be disclose under this authorization at my request, as permitted by 164.508©(1)(iv) of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). I acknowledge that I have received a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for the revocation to the Company.

This release will remain in effect and valid for 90 days from date of signature