Clear Form

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AMERICAN NATIONAL

AMERICAN NATIONAL INSURANCE COMPANY

P.O. BOX 10546 SPRINGFIELD MO 65808-0546 (800) 899-6520

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ to disclose my protected health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information to use the Health Information to determine payment or for other health care operations. Description of information to be released (check all that apply)

- ☐ Admission Summary
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports
- ☐ Radiology Films
- ☐ Radiology Reports
- ☐ Laboratory Report
- ☐ Emergency Room
- ☐ All medical records for diagnosis and treatment during the last five (5) years
- ☐ Other: _____

_____ Patient Name

_____ Date of Birth

_____ Plan Number

_____ Date(s) of Service

_____ Medical Records Number

I understand the released information will be mailed to the address above. I understand that if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire in 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.

I understand that I may revoke this authorization, except to the extent that action has been taken in reliance on it, by sending written notice to the Company or its Home Office. I also understand that I may refuse to sign this authorization, and such refusal may affect my ability to obtain health/disability benefits.

Signature of Patient _____ Date _____

(Beneficiary/Parent or Legal Guardian, if Minor)

Personal Representative section

Signature _____ Date _____

Personal Representative designated by the signature above is hereby authorized to execute this instrument based on:

(please check only one)

- ☐ Power of Attorney
- ☐ Guardian-in-Fact
- ☐ Guardian
- ☐ Payee Representative
- ☐ Other (please specify): _____