AUTHORIZATION & RELEASE TO DISCLOSE HEALTH INFORMATION

Purpose.
This document is executed to permit employees or agents of Erickson Financial Services, Inc ("Agent") to provide personal attention to your various insurance needs, including but not limited to assistance with claims and billing issues related to your individual health insurance needs, as well as for marketing of other insurance services.

Type of Information Requested. We request your permission to obtain, use and disclosure the following type of information about you for the limited purposes identified herein:

1. Claims information for any claims incurred since the date of this Release until the date that this release has been revoked by party executing this Release.
2. Claim information for any specific claims which occurred prior to the execution of this Release as identified herein: ____
____
____.
3. Other personally-identifiable health information.

Purpose For Which Information Will Be Shared. The information identified above will be shared only for purposes of evaluating and securing contracts for various employee or individual benefit plans (e.g. life insurance, disability insurance, voluntary products), to provide assistance to you and your covered dependents with regard to claim payments, appeals or related issues, other marketing purposes as disclosed verbally or in writing to you and to adding benefits to, renewing, replacing or amending coverage under Your Individual Health Insurance policy.

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1. **Persons Authorized to Make Disclosures.** The following persons are authorized to make the requested uses and disclosures of the information identified herein: Your individual health insurance policy, insurance agents or brokers or any other person or entity performing functions on behalf of the individual health insurance plan, and insurance carriers that provide benefits to you or to Your Individual Health Insurance policy.

2. **Persons to Whom Disclosures May be Made.** The information identified herein will be disclosed only to the following persons for the purposes identified herein:
   - Insurers, other health plans and third-party administrators that provide or administer the benefits identified above or that Your Individual Health Insurance policy may request provide potential coverage or a quote for such coverage;
   - Insurance agents and brokers acting on your behalf for your Individual Health Insurance coverage needs; and
   - Any other person or entity performing functions on behalf of your Individual Health Insurance policy, including any dependent who may also be covered on the policy.

3. **Expiration Date and Revocation.** This authorization shall remain in effect for the duration of the health insurance policy's term. However you retain the right to revoke this authorization before that date in writing to:

   Scott R. Erickson
   Erickson Financial Services, Inc.
   2130-F Academy Cir.
   Colorado Springs, CO 80909
   PH: 719-304-2250
   FAX: 719-328-0107

   I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

4. **Consequences of Refusal to Sign or Subsequent Revocation.** I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

5. **Reuse and redisclosure of information.** Information disclosed under this authorization is subject to redisclosure by the recipient, however any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators, will continue to be protected and not

be reused or redisclosed other than as authorized by you or permitted by law. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

6. **Scope of Disclosure.** I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I have read and understand the information above and with my signature below authorize the receipt, use and disclosure of the information described in this document for the limited purposes identified herein. No promises or representations have been made to me to induce me to sign this form.

______________________________ ______________________________
Customer Signature Customer Name

____
Date Signed

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of ____________________
(Name of Client)

signed by______________________________ on ____________________
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective ____________. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

(Signature of Client)	*(Date)*	*(Signature of Witness)*	*(Date)*
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*	

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by ____________________
(Name of Client or Personal Representative)

on ____________________. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*