

Authorization For Release Of Personal Health Information

This authorization is designed to comply with the HIPAA Privacy Rule.

I hereby authorize any health plan, health care provider or health care clearinghouse that has provided payment, treatment or services to the Patient or on his or her behalf to release to the persons or entities identified in Paragraph Number 1 information it has about the Patient's physical or mental health. Paragraph Number 2 describes the class of persons or entities hereby authorized to release personal health information about the Patient. These persons or entities may disclose the information described in paragraph Number 3.

Proposed Insured (Patient's Name)

Date of Birth

Social Security Number

Additional Insured (Patient's Name)

Date of Birth

Social Security Number

1. The records and information will be disclosed to The Ohio National Life Insurance Company or Ohio National Life Assurance Corporation, (Ohio National) P.O. Box 237, Cincinnati, Ohio 45201 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. Persons or entities hereby authorized to disclose personal health information about the Patient: Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. [MIB]) or other health care provider, the Veterans Administration; a consumer reporting agency and employer.
3. Description of the information that may be disclosed: This authorization specifically includes the release of the Patient's entire medical record and any other protected health information concerning the Patient including, without limitation, office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to the Patient. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. You may also disclose any financial, employment or personal information requested for insurance purposes.

The purpose of this disclosure is to evaluate an application for insurance or claim for benefits.

Ohio National may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim thereunder; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This authorization is good, as needed, for 26 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I have received Ohio National's Notice of Information Practices.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to Ohio National. Actions taken in reliance of this Authorization will not be affected, but no further actions will be taken in reliance of this Authorization after revocation is received by Ohio National. Revocation of this Authorization may result in the refusal to offer insurance coverage or pay benefits under a policy that has been issued.

Signature of Patient (Proposed Insured)

Date

Signature of Patient (Proposed Additional Insured)

Date

If signed on behalf of Patient (Proposed Insured), the signer is the Patient's:

Parent/Guardian of minor

Other (specify) _____

If signed on behalf of Patient (Proposed Additional Insured), the signer is the Patient's:

Parent/Guardian of minor

Other (specify) _____