AUTHORIZATION TO DISCLOSE HEALTH INFORMATION AND OTHER RECORDS

Insured/ Patient Name: _____ Date of Birth: _____

Insured /Patient Address: _____ SS#: _____

Claim #: _____ Medical Record Number (if applicable): _____

I, THE INSURED/ PERSONAL REPRESENTATIVE ACTING ON BEHALF OF THE INSURED, HEREBY GRANT PERMISSION AND AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE ABOVE NAMED INDIVIDUAL'S RECORDS AS DESCRIBED BELOW TO **AIG Travel, Inc., AIG Claims Inc., AIG Global Investigative Services, National Union Fire Insurance Company of Pittsburgh, PA, The Insurance Company of the State of Pennsylvania, and any affiliated companies ("the Companies"), and their employees, agents, and authorized representatives ("the Recipient").**

THE FOLLOWING INDIVIDUAL(S), MEDICAL PROVIDER(S), AND/OR ORGANIZATION(S) ARE AUTHORIZED TO MAKE THE DISCLOSURE:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above)) which may have provided the Insured with coverage of the type(s) for which they are seeking benefits;
- any consumer reporting agency or insurance support organization;
- the Insured's employer, group policyholder, or benefit plan administrator.

SPECIFY RECORDS: Check the box and initial below to specify which type of information is to be disclosed

☐ HEALTH INFORMATION (All information related to the Insured's health (except psychotherapy notes) including, but not limited to, medical reports, SOAPE notes and all other notes (typed or handwritten), records, charts, letters, physical therapy records, lab reports, medical consultations, treatments, surgeries, hospital confinements for physical or mental conditions, drug prescriptions outpatient reports and discharge summary)
☐ MEDICAL BILLING
☐ X-RAYS/FILMS (MRIs, CT-Scans, and Reports)
☐ Personnel, Attendance, Employment, Payroll, Wage Records from an Employer or School
☐ Insurance records, including all policies and claims, itemized billing, correspondence, payments, and all documents within the file
☐ Drug/Alcohol Information _____ *(initial)*
☐ Psychiatric Information (excluding psychotherapy notes) _____ *(initial)*
☐ Results of an HIV Blood Test _____ *(initial)*
☐ Other: _____

☐ Exclusions: _____

USE: I understand that the information will be used by the Recipient to determine the Insured's eligibility for benefits or damages under an insurance policy or for the contestability of such policy; to identify, detect or prevent fraud or abuse; or for compliance activities, which may include disclosure to public and quasi-public agencies engaged in fraud prevention or fraud detection programs.

REVOCATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation via email to: claimsdoc@aig.com or via mail to:
AIG Claims, PO Box 47, Stevens Point, WI 54481. I understand that revocation will not apply to the Companies to the extent they have taken action in reliance on information provided in connection with this authorization or where the law provides the right to contest a claim under the policy or the policy itself.

DURATION: Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

I understand that signing this authorization is voluntary and the Companies cannot require the Insured to sign the authorization to receive treatment or payment or to enroll or be eligible for benefits. However, the Companies may not be able to obtain the information necessary to consider a claim for benefits if the authorization is not signed. I understand that I am entitled to a copy of this authorization and acknowledge receipt of such copy. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy regulations. A copy of this authorization is as valid as the original.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Rep., Relationship to Patient (please print)