AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health Information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, not including my psychotherapy notes, to give out my medical information (Information) includes and extends to verbal or written form as explained as specified below:

1. **Classes of Persons Authorized to Disclose My Protected Health Information**: I authorize each doctor, hospital, laboratory, nurse, physician, pharmacy, physician clinic or practice group and any other type of health care provider (each, an "Authorized HCP") having Information about me to disclose any and all of the Information provided under this authorization. I acknowledge that all of my Information in the possession of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic, facsimile or electronic copy or other reproduction of this authorization.

2. **Persons Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my Information under this authorization to ProActiveCM, any of its affiliates and any of their officers, employees, agents, independent contractors, authorized union representatives, service providers or other representatives (each, an "Authorized Recipient" or Claim Manager).

3. **Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure:** I allow the Claims Managers to use and give out any and all of my health and medical Information only to evaluate analyze, manage and/or administer my claim for disability (both occupational and non-occupational). **This authorization does not apply to psychotherapy notes.** I also allow the Claim Manager to give my Information to any other person or entity if needed to find out whether I am eligible for benefits, to manage my claim, or to run the Claims Program.

4. **Expiration of Authorization:** This authorization shall remain valid until, and shall expire on, the date that is one (1) year after the date on which the Claim has been either denied, settled, or paid in full, as applicable or unless the law requires a shorter period.

5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization at any time. If I change my mind before that time, I can tell my Authorized HCP in writing or by personal delivery that I do not want them to share any more Information. If I tell them in writing to sharing Information, it will not change any actions took before I told them.

6. **Consequences of Failure to Provide Authorization:** I understand and acknowledge that by not signing this form, it will not affect how my healthcare providers (HCPs) will treat me. My HCPs may not refuse to provide treatment or health care services to me. However, if I do not sign, my Claim Managers may not be able to review my claim and cannot find out whether I am eligible for benefits. This may result in the denial of my request for benefits.

7. **Redisclosure of Information:** I understand that once my Information is given out as allowed on this form, federal HIPAA laws may not protect it.

CERTIFICATION OF DISABILITY CLAIMANT

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all Information contained in this authorization is true and correct. I further certify to each Authorized HCP that this authorization is written in plain language, I understand the terms and consequences of this authorization. I know that I can see or obtain a copy of this form or any Information provided to the Claim Manager at any time.

_____ Date: _____
Claimant's Signature

_____
Print Claimant's Name

_____ Date: _____
Legal or Representative's Signature

_____ _____
Print Legal or Representative's Name Relationship, Authority, or Other Similar Status