AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION PERMISSION TO SHARE INFORMATION

A. Patient's Name *(please print)*:	**Date of Birth:** _____ | _____ | _____ Month Day Year	**Medical Record No.** *(if known)*:
Address:	**Telephone Number:**	**Social Security Number** *(last 4 digits)*:

B. PERMISSION TO SHARE: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

FROM / BETWEEN *(circle one)*: **Name:** _____ **Address:** _____ _____ **Fax Number:** _____ **Telephone No.:** _____	**TO / BETWEEN** *(circle one)*: **Name: FinLife Asset Services, Inc.** **Address: 2263 SE 15th St., Pompano Beach, FL 33462** **Fax Number: +1 (954) 991-1433** **Telephone No.: +1 (954) 991-1433**

I, _____ *(name of individual)*, authorize disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the **Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:**

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, Pharmacy Benefit Manager, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose all my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photo static or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to **FinLife Asset Services, Inc.**, any of their affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, service providers or other representatives (each, an "Authorized Recipient").

3. Protected Health Information Authorized for Disclosure: This authorization shall apply to all my health and medical data, information, and records, whether personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This information may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

4. Purpose of Disclosure: This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition and life expectancy in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured and (2) to monitor, track or verify my life, health or medical status and condition in connection with any life insurance policy under which my life is insured.

5. Expiration: I understand this authorization will remain until the later of two (2) years after the date of my signature below or one (1) year after the date of my death.

6. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation; or by notifying **FinLife Asset Services, Inc.** in writing, addressed as set forth below. Notices shall be deemed given as of the date received or on the date shown on the receipt or confirmation, therefore.

7. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization: No HCP or other covered entity may condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent, or an authorization requested by a health care provider, health care clearing house or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, because of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

PATIENT OR INDIVIDUAL

Signature: _____

Printed Name: _____

Date: _____

PERSON AUTHORIZED TO SIGN ON BEHALF OF PATIENT OR INDIVIDUAL*

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Date: _____

For example: *Power of Attorney, Guardian ad Litem or similar status; please attach a copy of any official documentation confirming this status.*