CSO P.O. Box 34350 • Omaha, NE 68134-0350
1-800-826-6587 • Fax: 1-800-325-9116
Central States Health & Life Co. of Omaha
Credit Insurance Administrator for First National Life Insurance Company *of the* USA

When faxing forms, please follow up with originals by mail.

# AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I hereby authorize any Medical Persons and Entities to use or disclose Personal Information/Medical Records to Central States Health & Life Co. of Omaha (CSO) and any other entities acting on behalf of the Administrator regarding:

Patient's Full Name:_____

Other names by which the patient may have been known by:_____

Date of Birth: _____ If deceased, Date of Death: _____

Patient's Address: _____

The Personal Information being disclosed may be used to determine eligibility for insurance, resolve or contest any issues of incomplete, incorrect or misrepresented information on the application; or determine eligibility for benefits.

Information to be released can be mailed or faxed to:

ATTN Claims Department
Central States Health & Life Co. of Omaha
PO Box 34350 Omaha, NE 68134-0350

or

ATTN Claims Department
Secure Fax: 1-800-325-9116

## Meanings of Terms

**"Medical Persons and Entities"** means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, all other providers of medical or dental services, Central States Health & Life Co. of Omaha and other insurance companies.

**"Personal Information"** means: all health information, such as medical history, entire medical records, mental and psychiatric records (excluding psychotherapy notes), prescription drug records, drug and alcohol use records and other information such as finances, occupation, general reputation and insurance coverage and claims information, about the patient. It may also include information, which may be considered a communicable or a sexually transmitted disease, which may include, but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and HIV infection.

## Potential of Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information would then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

## I Can Refuse to Sign - Consequences

I understand that I may refuse to sign this authorization. I realize that refusal to sign this authorization may result in the lack of necessary information needed to issue the insurance being applied for, or to process the claim being presented.

## Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for the earlier of the duration of the claim or for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Legal Department, Central States Health & Life Co. of Omaha, Credit Insurance Administrator for First National Life Insurance Company of the USA, P.O. Box 34350, Omaha, NE 68134-0350, and the entity that was authorized to disclose the information. The revocation is not effective until it is received by the entity that was previously authorized to disclose the information.

I realize that my right to revoke this authorization is limited to the extent that the Administrator has taken action in reliance on the authorization or the law provides the Administrator with the right to contest the policy itself.

## Copy

I understand that I have a right to receive a copy of the signed authorization. I also understand that a copy of this authorization is as valid as the original.

_____ _____
Patient Signature (if living), otherwise signature of Personal Representative / Next of Kin — Date

_____ _____
If patient is deceased, printed Name of Personal Representative / Next of Kin — Relationship to Patient

_____
Address — City, State and Zip — Phone No.

**List names of physician(s)/health care provider(s) who have treated the patient within the last 3 years, including the names of all pharmacies used in the last 3 years. Attach additional sheet if necessary.**

| | | | |
|---|---|---|---|
| Primary Physician | Address | Phone No. | Dates of Treatment |
| Physician/Health Care Provider/Pharmacy | Address | Phone No. | Dates of Treatment |
| Physician/Health Care Provider/Pharmacy | Address | Phone No. | Dates of Treatment |
| Physician/Health Care Provider/Pharmacy | Address | Phone No. | Dates of Treatment |
| Physician/Health Care Provider/Pharmacy | Address | Phone No. | Dates of Treatment |