Authorization to Release Medical Information

Patient's Name	Date of Birth	SSN

PLEASE READ CAREFULLY

Information to be Released: Any information deemed by ***Bardon Insurance Group, Inc.*** to be necessary for making an appropriate underwriting and / or claims adjudication decision. Including but not limited to: medical records, mental health records, substance abuse records, HIV records, results from diagnostic testing and / or telephonic interviews with the provider or the provider's authorized designee.

Purpose of this Authorization: Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of stop loss insurance / excess of loss insurance for a employer sponsored health and welfare benefit plan, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (as defined in C.F.R. Title 45 Subtitle A 164:501).

Parties Authorized to Receive the Information: ***Bardon Insurance Group*** (a managing general underwriter for medical stop-loss insurance / excess of loss insurance and life insurance), ***Case Management Specialists*** (a third party medical consulting / case management firm), and / or any entity that Bardon Insurance Group may reasonably see fit.

Expiration: This authorization will be valid for 12 months from the date that it is signed.

Right to Revoke: You may revoke this authorization at anytime by writing to: Bardon Insurance Group, Director of Underwriting, 8326 E. Hartford Drive, Suite 100, Scottsdale, AZ 85255. The revocation will be effective from the date received by Bardon Insurance Group, Inc.

Special Notice: Signing this release or any information obtained as a result will not affect your coverage under your employer's benefit plan. You do have the right not to sign the release. When health information is disclosed to anyone except a covered entity it would no longer be protected under HIPAA regulations.

Parties Authorized to Release the Information:

Providers Name	Phone Number (with area code)

By signing below, I acknowledge that I have read and understand this release and authorize the release of my health information as described above. In addition, I understand that a photocopy of this form shall be as valid as the original.

X	
Signature of Patient (parent / guardian if patient is a minor or legal representative if the patient is unable to sign either physically or not legally competent to do so.) Please indicate relationship to patient below:	**Date Signed**
Relationship to Patient	