AUTHORIZATION FOR MEDICAL RELEASE

Insured Name_____ Patient Name_____

Policy # / SS #:_____

Doctor #1:
Name:_____

Phone Number:_____ Fax Number:_____

Doctor #2:
Name:_____

Phone Number:_____ Fax Number:_____

Doctor #3:
Name:_____

Phone Number:_____ Fax Number:_____

I authorize any licensed doctor, practitioner of healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advise, treatment, diagnosis or prognosis of any physical or mental condition, or employment status regarding myself or my dependents, to provide this information to Valenz Health or any agent or administrator acting on its behalf. By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed. I understand that information about my health may be released as required or permitted by law. Health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and no longer be protected under federal law. I have a right to revoke this authorization in writing, by sending a written request to Valenz Health, at 300 North Meridian Street, Suite 1710, Indianapolis, IN 46204, Attention: Stop Loss. I acknowledge that upon such revocation, information about my health may be continued to be used for treatment, payment and health care operations; and such revocation is not effective to the extent Valenz Health has relied on the use or disclosure of my health information.

Print Name_____

Signature of Insured_____Date_____