Authorization for Release of Information

Release information from the record(s) of: _____
(Last Name) (First Name) (Middle)

Date of Birth: ____/____/_____ Soc. Sec. No. (last 4 digits): _____

I authorize the following parties to give the information noted below to Combined Insurance Company of America (Combined) or its reinsurers for the purpose of evaluating this application for insurance or a claim: any Hospital; Physician; Medical Professional; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; or MIB, Inc., (formerly known as the Medical Information Bureau).

The information to be released includes my entire medical record, including physician and nurse notes, lab, pathology, and diagnostic test results, but does not include psychotherapy notes.

If checked below, I further authorize the release of sensitive information which may include diagnosis and/or treatment information concerning:

- ☐ Mental health (but NOT psychotherapy notes)
- ☐ HIV/AIDS
- ☐ Substance use disorder (alcohol / drug)
- ☐ Sexually transmitted diseases

I understand this consent may be revoked at any time by sending written notice to Combined Insurance Company of America, Attention: HIPAA Privacy Office, P.O. Box 6705 Scranton, PA 18505-0705. I understand this revocation will not apply to any information Combined requests or discloses prior to Combined receiving my revocation request. Unless a written revocation request is received, this authorization will be valid for a period of 24 months from the date of this authorization.

I understand that any disclosure of information carries with it the potential for re-disclosure and the information may then no longer be protected by Federal confidentiality rules.

SIGNATURE: _____ Date: _____

Patient or personal/legal representative (Next-of-kin or legal guardian to sign only if patient is a minor or legally incompetent).

PRINT NAME: _____

Relationship to patient or personal/legal representative signing for patient: _____

Please return this completed form to: Fax: (440) 386-2600 or

Mail: Chubb Life & Consolidated Billing
One Integrity Parkway
Attn: Underwriting
Cleveland, OH 44143