AUTHORIZATION TO DISCLOSE & RELEASE
PROTECTED HEALTH INFORMATION
(HIPAA Compliant)

Patient (Insured's) Name: _____

I, _____, the undersigned insured(s) (hereafter referred to as "I", "me" or "my"), authorize the disclosure of my protected health information ("PHI") as defined under the privacy regulations promulgated pursuant to the *Health Insurance Portability and Accountability Act of 1996* ("HIPAA") as follows:

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

2. Release Authority: I specifically authorize and request any HCP receiving this document to rely upon an original or reproduction (photo-static, facsimile, e-mail attachment, or other reproduction) of this authorization. I understand this release may be transmitted by **WHAT MATTERS FOR LIFE L.L.C.**, to an Authorized Recipient or Designee via e-mail, computer disk, facsimile, photo-static reproduction, and shall also be considered the same as the original.

3. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to **WHAT MATTERS FOR LIFE L.L.C.**, to any life/ viatical settlement company designated by **WHAT MATTERS FOR LIFE L.L.C.**, to any second opinion underwriting services designated by **WHAT MATTERS FOR LIFE L.L.C.**,, not limited to: 21st Services, American Viatical Services, Examination Management Services, or Fasano Associates, and/or to **WHAT MATTERS FOR LIFE**'s authorized representatives, successors, designees and affiliated entities, agents, subsidiaries, independent contractors, service providers and the officers, directors, and employees of each (each an "Authorized Recipient"). I understand that my PHI may be transmitted to an Authorized Recipient via e-mail, computer disk, facsimile, photo-static reproduction, via web posting to a secure website, or via FedEx, UPS, U.S. Postal Service, or any designated courier or delivery company or service.

4. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information, and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any designated life/viatical settlement provider, or their affiliates, subsidiaries, or corporate parents purchases.

1701 East Hennepin Avenue, Suite 285, Minneapolis, MN 55414
C – 612.804.7700 • F – 612.437.4881
www.whatmattersforlife.com

5. Expiration of Authorization: This authorization shall remain valid until one (1) year after the date of my death.

6. Right to Revoke Authorization: I understand 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.

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.

8. Release of PHI Information: I hereby authorize HCP to furnish **WHAT MATTERS FOR LIFE L.L.C.**, with any information or forms in connection with authorization. I further understand as a result 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 re-disclosure 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 as of the date written below 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.

_____ _____

NAME OF PATIENT (INSURED) **SIGNATURE OF PATIENT (INSURED)**

_____ _____

DATE OF BIRTH **SOCIAL SECURITY # OF INSURED**

_____ _____

NAME OF WITNESS **SIGNATURE OF WITNESS**

_____ _____ _____

SIGNED AT (CITY) **STATE OF** **DATE**

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