HIPAA Authorization for Release of Medical Information

Please fill out and mail this HIPAA Compliant Authorization form along with your application. We cannot begin to process your application until we receive the signed HIPAA form.

ADA No.

Print Name of Insured/Patient

Date of Birth / /

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, or holders of prescription information on me, including but not limited to: pharmacies and pharmacy benefits managers, and insurers, medical facilities, or other healthcare professionals that have provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West Life & Annuity Insurance Company (the Company). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West Life & Annuity Insurance Company may: 1) evaluate my application for insurance coverage or claims benefits, determine eligibility and risk rating; 2) obtain reinsurance; 3) administer coverage and claims; 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West Life & Annuity Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West Life & Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Great-West Life & Annuity Insurance Company except as authorized by me or as required by law.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign the Authorization to release my complete medical record, Great-West Life & Annuity Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

Signature of Insured/Patient

Date of Signature / /

Please fax completed form to Great-West Financial: 303.737.4843