Czechoslovak Society of America

HIPPA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE MEDICAL INFORMATION

_____ _____ /_____ /_____

Name of Proposed Insured only (please print) Date of Birth of Proposed Insured

_____

Social Security Number of Proposed Insured

I, the Insured above or the Personal Representative acting on behalf of the insured, hereby authorize the following physician:

_____ and any:

Name of Physician and/or Medical Facility

health plan, physician, and nurse or practitioner group, hospital, clinic, laboratory, pharmacy and pharmacy benefit manager, or other medical related facility, insurance support organization, government agency, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to the **CZECHOSLOVAK SOCIETY OF AMERICA**, or to any agent, attorney, consumer reporting agency or independent administrator; and all persons authorized to represent these organizations, including medical record retrieval services or pharmaceutical services, acting on behalf of the **CZECHOSLOVAK SOCIETY OF AMERICA** or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me including information relating to medical history, medical conditions, diagnosis and prognosis, treatment, hospitalizations or confinements, lab work, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information of the diagnosis and treatment of mental illness, but excludes psychotherapy notes. This information will be released in any format, including, but not limited to paper and/or electronic format, pursuant to this Authorization.

It is understood that this protected health information is to be disclosed under this Authorization so the **CZECHOSLOVAK SOCIETY OF AMERICA** may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer coverage; 4) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the **CZECHOSLOVAK SOCIETY OF AMERICA.** I understand that after this information is disclosed, the recipient may re-disclosed it resulting in loss of protection by federal regulations governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical records, the **CZECHOSLOVAK SOCIETY OF AMERICA** may not be able to process my life insurance application, or if coverage has been issued, may not be able to make any benefit payments. A copy of this authorization shall be valid as the original. I acknowledge that I have received a copy of this authorization.

Unless revoked earlier, this authorization is valid from the date signed for duration of 36 months or the duration of any claim for benefits under the Insured's insurance coverage, which is ever is later. I understand I may revoke this authorization at any time by sending written notice to the **CZECHOSLOVAK SOCIETY OF AMERICA, 2050 Finley Road, Suite 70, Lombard, Illinois, 60148,** except to the extent that action has been taken in reliance on this authorization, or during a contestability period under applicable law.

_____ _____

Signature of Proposed Insured
(or Parent if Proposed Insured is under age 18)

Print Name of Parent (if Proposed Insured is under age 18)
or Personal Representative

_____ _____

Signature of Personal Representative; designated by signature,
is hereby authorized to execute this instrument based on:
Power of Attorney, guardian, executor, or other

Date of Signature