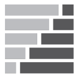
TruStage®
TruStage Financial Group

American Memorial Life
Insurance Company
P.O. Box 2730
Rapid City, SD 57709

Medical Authorization/ Release Form

This Authorization complies with the HIPAA Privacy Rule.

Please scan and return your completed, signed form to us by
Email: psdocuments@trustage.com
Fax: 1-605-719-0601

____________________________________ ________________
Name of Deceased/Patient Date of Birth

____
Policy Number(s) of Deceased

I, as authorized representative of the deceased, authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, Medical Information Bureau, LLC (MIB, LLC), laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran's Administration, the deceased's employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to the deceased (collectively, "The Providers") to disclose the entire medical record and any other protected health information concerning the deceased to American Memorial Life Insurance Company ("the Company") or its reinsurers, their agents, employees, and representatives. 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements to restrict protected health information do not apply to this authorization and I instruct The Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

This authorization shall remain in force for 24 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. I understand that a revocation is not effective to the extent that any of The Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that if I refuse to sign this authorization to release the complete medical record, the Company may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____ ______________________
Signature of Authorized Representative Date

Description of Authorized Representative's authority to sign on behalf of deceased:

☐ Parent of Unemancipated Minor ☐ Power of Attorney ☐ Legal Guardian ☐ Other________________

This form may be used for business underwritten or administered by American Memorial Life Insurance Company or Union Security Insurance Company, part of the TruStage Financial Group, Inc.