American Fidelity Assurance Company

2000 N. Classen Boulevard
Oklahoma City, Oklahoma 73106

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient/Insured Name: _____ Patient/Customer or Policy No.: _____
Date of Birth: _____

1. I authorize the use and disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

American Fidelity Assurance Company
P.O. Box 25523
Oklahoma City, OK 73125

For the purpose of: DISCOVERY BEFORE TRIAL

3. The type and amount of information to be used or disclosed is as follows:
Any and all health insurance claims records including, but not limited to, hospital and medical records and hospital and medical billing records.

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization (individual or organization requesting records):

RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054
SOUHTFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must present my revocation to the above individual or organization. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months. A photocopy of this authorization shall be as valid as the original.

7. I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure payment of claims, enrollment or eligibility for benefits. I understand I may receive a copy of this authorization. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information, I can contact American Fidelity Assurance Company, Attention: Privacy Official, P.O. Box 25523, Oklahoma City, Oklahoma 73125, or by calling 1-866-55-HIPAA, or by contacting the company at hipaa@af-group.com.

_____ _____
Signature of Patient/Insured or Personal Representative* Date

_____
If Signed by Personal Representative, Relationship to Patient/Insured

*If authorization is supplied by a Personal Representative, documentation of the authority to act on behalf of the Patient/Insured must be included.