HIPAA-COMPLIANT CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

(Optional Consent — You are not required to sign.)

Please clearly print all information.

This Consent will permit any physician, medical practitioner, hospital, clinic, Veterans Health Administration facility, pharmacy, insurance/reinsurance company, or other appropriate entity having information about the onset or cause, diagnosis, treatment, prognosis related to any physical or mental condition, including drug or alcohol abuse, communicable disease, accident, or injury of you or your minor children, as indicated below, to release to American Medical Security Life Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company (collectively PacifiCare), and/or its legal representatives any and all such information. The information you consent to release may include confidential information or a personal medical history for you or your minor children. This information will be used solely for the determination of benefits on the claim and will be held in strict confidence.

As required by state regulations, we need to inform you that the information you authorize for release may include documentation regarding the presence of a communicable disease or venereal disease. This information may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS).

If the documentation received includes information regarding domestic abuse/violence, we cannot use this as a basis for denying, refusing to issue, or canceling your coverage. Nor can this information be used as a basis to restrict or exclude coverage or benefits under your plan. We want to assure you that we are in no way indicating that your records will include this type of information.

This Consent will expire automatically following six months from the date of signature below. A copy of this document shall be as valid and effective as the original and is available upon request at any time. You may revoke this Consent at any time upon your written request.

I understand that information used or disclosed pursuant to this Consent may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law.

The nature of the information consented to be disclosed may include, but is not limited to, the following:

Anesthesia Notes	Drug/Alcohol/Substance Abuse Records	Nurses' Notes	Physicians' Orders
Consult Report	History and Physical	Operative Report	Police/Accident Report
Dental Records	Hospital Records	Pathology/Lab Reports	Progress Notes
Discharge Summary	Medical Records	Pharmacy Records	Therapy Records

If you or any of your dependents have used another name (for example, maiden name, stepchild, etc.), please write the name(s) here:

_____

_____

Customer Signature Date of birth/Last four digits of Social Security number Date

For child only, signature must be the child's parent or legal guardian if customer is not of legal age.

If signed by a representative of customer, please indicate the representative's authority to act on behalf of customer.

_____

_____

Spouse/domestic partner Signature (if spouse/domestic partner is covered) Date

Signature of each dependent age 18 and over

_____ _____

X Date X Date

_____ _____

X Date X Date

For copies of this Consent, visit *www.eAMS.com* and click on Privacy Policy or call (800) 232-5432, select 1 at the prompt and then enter Ext. 15201.

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Policy Identification Number Claim Number

For office use only.

PacifiCare®

A UnitedHealthcare Company

American Medical Security Life Insurance Company, 3100 AMS Blvd., P.O. Box 19032, Green Bay, WI 54307-9032, (800) 232-5432, provides administrative services for PacifiCare Life and Health Insurance Company and PacifiCare Life Assurance Company.

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