Authorization for Release of Health Information

Member's Full Name:	Date of Birth:	Member or Subscriber ID # (if known):

Member's Residence Street Address:	City:	State (or Country):	Post/ZIP Code:

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other persons or entities, including health care providers, and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying Worldwide Insurance Services LLC in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Who May Receive and Disclose My Information:

I authorize **Worldwide Insurance Services, LLC/4 Ever Life Insurance Company/4 Ever Life International Limited/BCS Insurance Company (or other pertinent underwriter), or my Self-Insured Health Care Plan Sponsor or Administrator** to disclose my individually identifiable health information to the following person(s) or organization(s):

1. (Full Name of Person(s) or Organization(s)):	2. (Full Name of Person(s) or Organization(s)):
3. (Full Name of Person(s) or Organization(s)):	**4. (Full Name of Person(s) or Organization(s)):**

Type of Information to be Disclosed (check only one):

○	**Psychotherapy notes** – Federal law requires a separate authorization to use or release psychotherapy notes. If you check this box, you may not check another box below. If you check this box and want to release information under either/both the options below, you will need to complete a separate form.
○	**All information** – related to the provision of and payment for my health care benefits and the provision of and payment for health care services, which includes comprehensive access to all my health care information found on the company website or through other methods. If you check this box, this allows for the release of all your information; you are therefore agreeing to release information concerning (1) Genetic information, (2) Substance/Alcohol Abuse, (3) HIV/AIDS and (4) Mental/Behavioral Health. If you do not wish to release the information on any or all of these referenced four categories, please use the following box to indicate the limited scope of information you authorize to be released.
○	**Specific information** – I authorize only the disclosure of the following information:

Authorizing signature follows on next page.

Expiration - this information will expire (check one):	
◯	**When I revoke this authorization***
◯	**Upon the following date, event or condition*:**

*Note: this authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

My health information is being disclosed at my request or at the request of my personal representative:	
Signature of Member:	**Date:**
Witness Signature (For Illinois Residents Only):	**Date:**

For parents of minor children, guardians or court-appointed representatives (collectively referred to as Personal Representative)

If you are a guardian or court-appointed representative, you must attach a copy of your legal authorization (e.g., Power of Attorney, court order, etc.) to represent the member and complete the following:

Personal Representative Name:	**Phone Number:**	**Email address:**	
Street Address:	**City:**	**State (or Country):**	**Post/ZIP Code:**
Signature of Personal Representative:		**Date:**	

(For California and Georgia residents only) I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

PLEASE MAINTAIN A COPY OF THIS FORM FOR YOUR RECORDS AND RETURN IT TO:

Worldwide Insurance Services, LLC
Attn: Privacy Officer
933 First Avenue
King of Prussia, PA 19406
Phone Number: 1.610.254.5304
Fax Number: 1.610.293.3529