



## AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

• THIS FORM COMPLIES WITH THE HIPAA PRIVACY RULE. •

I AUTHORIZE ANY PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, PHARMACY BENEFIT MANAGER, OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY, EMPLOYER, CONSUMER REPORTING AGENCY, AND THE MIB TO GIVE TO SONS OF NORWAY OR ITS REINSURERS, ANY AND ALL INFORMATION AVAILABLE REGARDING THE DIAGNOSIS, TREATMENT AND PROGNOSIS OF ANY PHYSICAL OR MENTAL CONDITION ABOUT ME. THIS AUTHORIZATION SHALL EXTEND TO ANY SUCH INFORMATION RELATING TO ANY CHILDREN TO BE INSURED UNDER THIS APPLICATION.

I UNDERSTAND THAT MY HEALTH RECORD MAY INCLUDE INFORMATION PERTAINING TO THE TREATMENT OF DRUGS AND ALCOHOL ABUSE, MENTAL ILLNESS, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV), SEXUALLY TRANSMITTED DISEASES OR TUBERCULOSIS.

I UNDERSTAND THE INFORMATION OBTAINED BY USE OF THIS AUTHORIZATION WILL BE USED BY SONS OF NORWAY TO DETERMINE ELIGIBILITY FOR INSURANCE AND/OR ELIGIBILITY FOR BENEFITS UNDER AN EXISTING CERTIFICATE. I AUTHORIZE SONS OF NORWAY OR ITS REINSURER TO MAKE A BRIEF REPORT OF MY PERSONAL HEALTH INFORMATION TO MIB. ANY INFORMATION OBTAINED BY SONS OF NORWAY WILL NOT BE RELEASED TO ANY PERSON OR ORGANIZATION EXCEPT TO MIB, REINSURANCE COMPANIES, OR OTHER PERSONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH MY APPLICATION OR CLAIM. I AGREE THAT A COPY OF THE AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I ACKNOWLEDGE RECEIPT OF AND UNDERSTAND THE FAIR CREDIT REPORT AND MEDICAL INFORMATION BUREAU NOTICES. I AGREE THAT THIS AUTHORIZATION SHALL REMAIN VALID FOR TWO YEARS FROM THE DATE SHOWN BELOW.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT MY REVOCATION MAY BE IN WRITING AND ADDRESSED TO THE PRIVACY OFFICER AT SONS OF NORWAY, 1455 WEST LAKE STREET, MINNEAPOLIS, MN 55408. I UNDERSTAND THAT THE REVOCATION DOES NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION.

I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. I UNDERSTAND THAT I NEED NOT SIGN THIS AUTHORIZATION TO ASSURE TREATMENT. I UNDERSTAND THAT I MAY INSPECT AND/OR COPY THE INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT AUTHORIZING THIS DISCLOSURE IS VOLUNTARY AND THAT IF I HAVE QUESTIONS ABOUT DISCLOSURE OF MY HEALTH INFORMATION, I MAY CONTACT THE PRIVACY OFFICER AT SONS OF NORWAY AND REQUEST A COPY OF THIS AUTHORIZATION.

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SIGNATURE OF PROPOSED INSURED (IF AGE 16 OR OVER)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN  
(IF PROPOSED INSURED IS UNDER AGE 16)

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
WITNESSED BY REPRESENTATIVE

\_\_\_\_\_  
CITY AND STATE WHERE SIGNED