AUTHORIZATION AND RELEASE TO DISCLOSE HEALTH INFORMATION

Purpose. This document is executed to:

1. Ensure that **ADM Benefit Plans Agency, Inc.** does not obtain, use or disclose legally protected health or medical information about you without your permission or for purposes other than those that are permitted by law; and
2. Permit employees or agents of **ADM Benefit Plans Agency, Inc** to provide personal attention to your various insurance needs, including but not limited to assistance with claims, billing, and marketing of other insurance services.

Type of Information Requested. We request your permission to obtain, use and disclose the following type of information about you for the limited purposes identified herein:

1. Claims information for any claims incurred since the date of this Release until the date that this release has been revoked by party executing this Release.
2. Claim information for any specific claims, which occurred prior to the execution of this Release as identified herein:

   _____

   _____ .

3. Other personally-identifiable health information.

Purpose for Which Information Will Be Shared. The information identified above will be shared only for purposes of evaluating and securing contracts for various employee or individual benefit plans (e.g. life insurance, disability insurance, voluntary products), to provide assistance to you and your covered dependents with regard to claim payments, appeals or related issues, other marketing purposes as disclosed verbally or in writing to you and to adding benefits to, renewing, replacing or amending coverage under Your Group Plan.

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1. **Persons Authorized to Make Disclosures.** The following persons are authorized to make the requested uses and disclosures of the information identified herein: Your Group Plan, its administrator, insurance agents or brokers or any other person or entity performing functions on behalf of Your Group Plan, and insurance carriers that provide benefits to you or to Your Group Plan.

2. **Persons to Whom Disclosures May Be Made.** The information identified herein will be disclosed only to the following persons for the purposes identified herein:
   - Insurers, other health plans and third-party administrators that provide or administer the benefits identified above or that Your Group Plan may request provide potential coverage or a quote for such coverage;
   - Insurance agents and brokers acting on behalf of Your Group Plan;
   - Your Group Plan's administrator (if applicable); and
   - Any other person or entity performing functions on behalf of your Group Plan.

3. **Expiration Date and Revocation.** This agreement shall expire at the termination of your coverage through continuation under state or federal law. However, you retain the right to revoke this authorization before that date in writing to:

   Dawn Ratliff
   ADM Benefit Plans Agency, Inc
   P O Box 624
   Bucyrus, OH 44820
   800-851-0814
   419-562-4935 fax

   I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the Revocation Section on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

4. **Consequences of Refusal to Sign or Subsequent Revocation.** I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

5. **Reuse and re-disclosure of information.** Information disclosed under this authorization is subject to re-disclosure by the recipient, however any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators, will continue to be protected and not be reused or re-disclosed other than as authorized by you or permitted by law. However, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

6. **Scope of Disclosure.** I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I have read and understand the information above and with my signature below authorize the receipt, use and disclosure of the information described in this document for the limited purposes identified herein. No promises or representations have been made to me to induce me to sign this form.

_____
Client Name

_____
Client Signature

_____
Date Signed

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by_____ on _____
(Enter Name of Person Who Signed Authorization) *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____ _____
(Signature of Client) *(Date)*

_____ _____
(Signature of Witness) *(Date)*

_____ _____
(Signature of Personal Representative) *(Date)*

_____
(Personal Representative Relationship/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Client or Personal Representative)

on _____. The client or his personal representative has been informed that any
(Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) *(Date)* *(Signature of Witness)* *(Date)*