The Standard Life Insurance Company of New York

Individual Disability Benefits 800.378.6057 Tel 971.321.5609 Fax
900 SW Fifth Avenue Portland OR 97204

Reset

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK TO GIVE THIS INFORMATION:

Please check "Yes" for each type of information that The Standard Life Insurance Company of New York (The Standard) is authorized to release. The Standard will only release information where a "Yes" answer has been provided.

Yes ☐ No ☐ **MEDICAL INFORMATION INCLUDING:** Chart notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:

- Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
- Any communicable disease or disorder.
- Any psychiatric or psychological condition, including psychotherapy notes, test results, summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
- Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

Yes ☐ No ☐ **NON-MEDICAL INFORMATION INCLUDING SUCH THINGS AS:** Education, employment history, earnings or finances, vocational evaluation reports, vocational testing and rehabilitation plans, or eligibility for other benefits including retirement benefits and retirement plan contributions *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, claim status, benefit amounts and effective dates, etc.).*

Yes ☐ No ☐ **INFORMATION ABOUT MY COVERAGE(S) AND BENEFITS ADMINISTERED BY THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK INCLUDING:** All information about benefits paid or payable to me including amounts and offsets, payment dates, payment periods and any scheduled reduction or termination of my claim(s).

TO: _____

(Name of Spouse/Agent/Individual/Organization/Corporation/Government Agency/Other)

_____

(Street Address/City/State/Zip)

FOR THE FOLLOWING PURPOSES: _____

_____

- I understand and agree that this authorization will remain in force for one year from the date below. I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records or information.
- I understand that The Standard complies with state and federal laws and regulations enacted to protect my privacy. I acknowledge that I have read this authorization.
- A photocopy or facsimile of this authorization is as valid as the original.
- I understand that I have a right to receive a copy of this authorization upon request.

Name *(Please Print)* _____ Social Security Number _____

Claim Number _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Print