



**THE
KEMPTON
COMPANY**

ADMINISTRATOR, ADVANTAGE HEALTH PLANS

REQUEST FOR RELEASE OF MEDICAL RECORDS

I request that my medical records be released to:

The Kempton Company
PO Box 54889
Oklahoma City, Oklahoma, 73154-1889

I authorize any physician, medical practitioner, hospital, medical clinic, other provider of health care, any insurance company, any consumer reporting agency, or employer to disclose to The Kempton Company or its authorized medical underwriting and claims representatives all information and records relating to a diagnosis, treatment, medical history, physical and mental condition and evaluation or any other information relating to me or my dependent children. I understand that the information authorized for release may include records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to: diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV), also known as the acquired immune deficiency syndrome (AIDS). Such records and information may be used by the Kempton Company now, or in the future, in connection with the underwriting of my application for insurance the reinstatement renewal or continuation of any policy issued and any claims on any policy issued. I understand that any information obtained will not be released by the Kempton Company to any person or organization, except its reinsurers, other persons or other organizations performing business or legal services in connection with my application or policy or as maybe required by law or as I may further authorize. Information obtained will not be released except as may be required by law. A photo copy of this authorization shall be as valid as the original. For the purpose of collecting information in connection with a claim for benefits under coverage resulting from this application, this authorization remains valid for the term of coverage if the claim is for a health insurance benefit or the duration of the claim if the claim is not for a health insurance benefit. For all other purposes, this authorization remains valid for 30 months from this date.

INDIVIDUAL'S SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal representative's Name: _____

Relationship to Individual: _____

When requesting medical information for clinical review, we will respect privacy guidelines and confidentiality as defined in the HIPAA regulations.

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.