

MEDICAL RECORD RELEASE OF INFORMATION

Patient Name _____ Medical Record #/SS# _____
Date of Birth _____ Home Telephone _____ Work _____
Address _____ City/State/Zip _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Physician/Clinic Name _____
Address: _____
City/State/Zip _____

The type and amount of information to be used or disclosed is as follows:

- 2 years back with most recent test results
- 5 years back with most recent test results
- Specific information _____

Restrictions: Only medical records that have originated through this health care facility will be photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Syndrome (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Specific Solutions, Inc.
Street: 475 International Drive
City/State/Zip: Williamsville, NY 14221

For the purpose of: Life insurance

- Please mail copies to the address indicated in previous box.
- Please fax request to (716) 632-6051

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event of condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

(Date)

Signature of Patient

(Witness)

If signed by patient's authorized representative

Signature of Patient, guardian, or authorized representative

Printed name of authorized representative Relationship

Address and telephone number of authorized representative

ALLIANZ LIFE OF NY
 AMERICAN GENERAL LIFE INSURANCE CO
 AMERICAN INDEPENDENT NETWORK INS CO OF NY
 AMERICAN NATIONAL LIFE INSURANCE CO
 AMERICAN PROGRESSIVE LIFE & HEALTH INSURANCE CO OF NY
 AVIVA LIFE INSURANCE CO OF NY
 AXA EQUITABLE LIFE INSURANCE CO
 BANNER LIFE INSURANCE CO
 BERKSHIRE LIFE INSURANCE CO OF AMERICA
 COLUMBIAN MUTUAL LIFE INSURANCE CO
 COMPANION LIFE INSURANCE CO
 CONSECO LIFE INSURANCE CO OF NY
 FIRST AMERITAS LIFE INSURANCE CO
 FIRST METLIFE INVESTORS INSURANCE CO
 FIRST PENN PACIFIC LIFE INSURANCE CO
 FIRST UNUM LIFE INSURANCE CO
 GENWORTH LIFE INSURANCE CO
 GENWORTH LIFE INSURANCE CO OF NY
 HARTFORD LIFE INSURANCE CO
 INDIANAPOLIS LIFE
 ING RELIASTAR LIFE INSURANCE CO
 ING RELIASTAR LIFE INSURANCE CO OF NY
 JOHN HANCOCK LIFE INSURANCE CO
 JOHN HANCOCK LIFE INSURANCE CO OF NY
 LIBERTY LIFE ASSURANCE CO OF BOSTON
 LIFE INSURANCE CO OF THE SOUTHWEST
 LINCOLN LIFE AND ANNUITY CO OF NY
 LINCOLN NATIONAL LIFE INSURANCE CO
 MASSACHUSETTS MUTUAL LIFE INSURANCE CO
 MED AMERICA INSURANCE CO OF NY
 METLIFE INSURANCE CO OF CT

METLIFE INVESTORS
 METROPOLITAN LIFE INSURANCE CO
 MUTUAL OF OMAHA
 NATIONAL LIFE INSURANCE CO
 NATIONWIDE LIFE INSURANCE CO
 NEW ENGLAND LIFE INSURANCE CO
 NORTH AMERICAN CO FOR LIFE AND HEALTH
 PENN MUTUAL LIFE INSURANCE CO
 PHOENIX HOME LIFE MUTUAL INSURANCE CO
 PRESIDENTIAL LIFE INSURANCE CO
 PRINCIPAL LIFE INSURANCE CO
 PROTECTIVE LIFE AND ANNUITY INSURANCE CO
 PROVIDENT LIFE AND CASUALTY INSURANCE CO
 PRUDENTIAL INSURANCE CO OF AMERICA
 SECURITY MUTUAL LIFE INSURANCE CO OF NY
 STATE LIFE INSURANCE CO
 SUN LIFE ASSURANCE COMPANY OF CANADA
 SUN LIFE INSURANCE AND ANNUITY CO OF NY
 TRANSAMERICA FINANCIAL LIFE INSURANCE CO
 TRANSAMERICA OCCIDENTAL LIFE INSURANCE CO
 UNION CENTRAL LIFE INSURANCE CO
 UNITED OF OMAHA LIFE INSURANCE CO
 UNITED STATES LIFE INSURANCE CO
 UNITY MUTUAL LIFE INSURANCE CO
 UNUM INSURANCE COMPANY OF AMERICA
 WEST COAST LIFE INSURANCE CO
 WILLIAM PENN LIFE INSURANCE CO OF NY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give any such information to The Specific Solutions Group or any one of the life insurance companies listed and its reinsuring companies.

A photographic copy of this authorization and acknowledgment shall be as valid as the original.

Date

X

Signature of Proposed Insured (or Parent, if Proposed Insured is a Minor)

4/24/2008





THE SPECIFIC SOLUTIONS GROUP

...the life, health, & variable product problem solvers

SPECIFIC SOLUTIONS, INC. • SSI EQUITY SERVICES, INC. • LONG & KATZMAN AND ASSOC.

475 International Drive • Williamsville, New York 14221

1 (800) 873-2345 • (716) 632-7777 • (716) 632-6051 Fax

Website
www.specificsolutions.com

SECURITIES OFFERED THROUGH SSI EQUITY SERVICES INC.

email
agency@specificsolutions.com

AUTHORIZATION FOR THE RELEASE OF PERSONAL HEALTH INFORMATION (THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE)

Name of Proposed Insured/Patient (please print)

Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to any one (or all) of The Specific Solutions Group of companies ("The Company"), its agents, employees, insurance support organizations, insurers, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I authorize release of all my records from

Name _____

Address _____

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by The Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical records without restriction.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that The Company may; 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance offers; and 3) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for through The Company.

The following groups of persons employed or working for The Company may use my personal health information which is described above: employees of the underwriting, administration, and any other personnel of The Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with The Company.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: The Specific Solutions Group, 475 International Dr., Williamsville, NY 14221. I understand that a revocation is not effective if The Company has relied on the protected health information disclosed to it. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, The Company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon receipt of your signed authorization, a copy will be provided to you. Any alteration of this form will not be accepted.

X

Signature of Proposed Insured/Patient or Personal Representative

Date

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above.

BUFFALO MEDICAL GROUP, P.C.
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH
INFORMATION (PHI)

I, _____
Name (REQUIRED)

Address (REQUIRED)

(Social Security Number)

Date of Birth: _____
(REQUIRED)
Daytime Phone: _____

To Be Completed by BMG Personnel Only: Medical Record Number: _____ Date Sent: _____ Sender (Please Print): _____ Signature of Sender: _____
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authorize release of my protected health information (PHI) FROM:
Name: _____ TO: Name: _____
Address: _____ Address: _____

This authorization expires: _____ (Unless otherwise stated,
authorization expires six (6) months from date of authorized signature)

I understand that I have the right to revoke this authorization at any time but that I must
do so in writing. This does not affect records sent out in reliance on this authorization
prior to receiving the revocation request.

I want the following information to be disclosed: (REQUIRED - Please specify):

The purpose of this disclosure is: (REQUIRED - Please specify):

Please be aware that information disclosed pursuant to this authorization is subject to
re-disclosure by the recipient and is no longer protected by this organization.

Signature of Patient or Representative (REQUIRED)

If representative, authority on which acting for the patient

Date: _____ **PATIENT TO RECEIVE COPY OF THIS FORM**
(REQUIRED)

REQUIRED fields must be completed for Release of Protected Health Information
Buffalo Medical Group, P.C. will not condition the provision of treatment on the provision of this authorization.