NATIONAL FAMILY CARE LIFE INSURANCE COMPANY
P.O. BOX 809043 DALLAS, TEXAS 75380 (972) 387-8553

PRINT FORM TO COMPLETE

MEDICAL RELEASE AUTHORIZATION (HIPAA Compliance)

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that treatment or payment cannot be conditioned on my signing of this authorization except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. *This authorization will expire one hundred and eighty (180) days from the date of my signature, unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

_____	_____	_____
Print Patient Name	Date of Birth	Social Security Number

Date(s) of Service: _____

Description of information to be released:

____ DISCHARGE SUMMARY	____ HISTORY & PHYSICAL	____ OPERATIVE REPORT
____ ITEMIZED BILLING	____ CARDIAC CATHERIZAT	____ PROGRESS NOTICE
____ CONSULTATION REPORT	____ ER RECORD	____ PATHOLOGY REPORT

* THE PURPOSE OF THIS DISCLOSURE IS FOR INSURANCE PURPOSES ONLY *

Please Forward All Requested Information To:

(Our toll-free number is 800.527.0996

NATIONAL FAMILY CARE LIFE
CLAIMS DEPARTMENT
P.O. BOX 809043
DALLAS, TX 75380

_____ _____

_____	_____
SIGNATURE	**DATE**
_____	_____
PRINT NAME	**RELATION TO PATIENT**

IMPORTANT: RETURN THIS FORM TO NFCL CLAIMS DEPT. DO NOT LEAVE AT HOSPITAL.