Authorization for Release of Health-Related Information - <u>Psychotherapy Notes</u>
To BOSTON MUTUAL LIFE INSURANCE COMPANY
120 Royall Street / Canton, MA 02021

_____ _____
Name of (Proposed) Insured/Patient (please print) Date of Birth

I authorize _____
Name of Doctor or other health care provider ("Providers") to disclose the psychotherapy notes concerning me to the Boston Mutual Life Insurance Company (BML) ,its employees, representatives and reinsurers.

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization**,

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 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 in writing**, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself**. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.**

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release the psychotherapy notes, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments**. I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

_____
Signature of Proposed Insured/Claimant/Patient or Personal Representative
Date_____
Description of Personal Representative's Authority or Relationship to Proposed Insured/Claimant /Patient_____

(*continued on back*)

DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE

I, the undersigned designate:

_____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured_____

Date_____