

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information (“PHI”) as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory and any other type of health care provider, health care clearinghouse and healthcare plan (each, an “Authorized HCP”) having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.
2. Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose my PHI under this authorization to (a) P&T Financial, (b) any viatical/life settlement provider, (c) any person who may seek to purchase any life insurance policy insuring my life or other insurance product I own, (d) any financing entity of a viatical/life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers, (e) any life expectancy provider, (f) any life insurance company that has issued a life insurance policy insuring my life, and (g) any of the respective affiliates, agents, employees, representatives, advisors, successors and assigns of any of the persons or entities covered in the immediately foregoing clauses (a) through (f), inclusive (each, an “Authorized Recipient”).
3. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure. This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including information relating to psychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to any Authorized Recipient and (b) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any Authorized Recipient purchases.
4. Expiration of Authorization. This authorization shall remain valid until, and shall expire, two (2) years from the date hereof.
5. Right to Revoke Authorization. I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized

HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. I understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to HIPAA (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

INDIVIDUAL:

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Print Insured's Full Name

\_\_\_\_\_, 20\_\_\_\_\_  
Date

WITNESS:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Witness Name

\_\_\_\_\_, 20\_\_\_\_\_  
Date