

# Disability RMS

Committed to a higher standard



**AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)  
(HIPAA COMPLIANT)  
(to be signed and dated by the insured/claimant)**

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and \_\_\_\_\_ *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS\*** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, \_\_\_\_\_ and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or \_\_\_\_\_ to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to \_\_\_\_\_. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid during the pendency of my claim and shall expire on the date my claim finally ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or \_\_\_\_\_ have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of, or my failure to sign this authorization may impair Disability RMS' and \_\_\_\_\_'s ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

\*If you reside in **California**: this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) as to each specific test.

\*\*If you reside in **Connecticut, Maine, or Massachusetts**: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) as to each specific test.

\*\*\*If you reside in **Vermont**: This authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Disability RMS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and Disability RMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: \_\_\_\_\_

Claimant Signature (or Authorized Representative) \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Description of Personal Representative's Authority [If applicable]:  
[\*If signed by authorized representative, attach verification of identity]