

Authorization for Release of Records



To _____

You are hereby authorized and directed by me to give to and/or exchange with Fortis Benefits Insurance Company, or to any of its representatives, all information relative to any physical or psychological condition, treatment or evaluation in your possession, whether or not prepared by you or at your direction. Hereby specifically authorize the release of all medical, psychiatric and psychological records including, but not limited to, notes, reports, raw test data, records for treatment related to HIV/AIDS, and for treatment relating to drug and alcohol use and/or abuse. I understand that the information obtained by use of this authorization will be used by Fortis Benefits Insurance Company to determine eligibility for benefits. Further, I understand, agree and specifically authorize, that, for purposes of case management, Fortis Benefits Insurance Company or its representatives may share with my attending physician, psychiatrist and/or psychologist any of the above information and/or materials in its possession. A photostatic copy of this authorization shall be as valid as the original. This Authorization is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not otherwise revoked, this Authorization shall be effective for the duration of my claim.

Signature _____ Date _____

Social Security number _____

Date of birth _____