

Claim#

Authorization to Release Information

I authorize and request the disclosure of all protected information by any licensed physician, hospital, clinic or other medical or related facility, insurance company, government organization, Social Security Administration, employer, or other organization, institution or person that has any records or knowledge of me, my health, (including any information relating to use of drugs or use of alcohol and any information relating to mental and physical history, condition, advice or treatment), my earnings or other insurance benefits to release this information to Baldwin and Lyons, Protective Insurance Company, and all duly authorized representatives. I expressly request that the designated records custodian of all entities covered under HIPAA disclose full and complete protected medical information for the purposes of administering any claims for benefits.

This consent shall be subject to revocation at any time except to the extent that the entity or person which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will expire upon final termination of all claims between the claimant and Baldwin and Lyons, Protective Insurance Company, and any duly authorized representatives.

I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering any and all insurance claims made for benefits and that I have waived the right for such information to be privileged.

A photocopy of this authorization shall be as effective and as valid as the original.

Claimant's Signature (Insured, otherwise authorized person) Date

Claimant's Printed Name Date