tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name ________________________________ Policy number ____________________
PLEASE PRINT

AUTHORIZATION: I authorize American Independent Network Insurance Company of New York, hereinafter referred to as "American Independent Network," to release information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by American Independent Network, to the following individuals:

Name (please print)	Relationship	Telephone number

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to American Independent Network at 3440 Lehigh Street, Allentown, PA 18103, and will become effective when received by American Independent Network. I understand that even if I revoke this authorization, American Independent Network will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given American Independent Network, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: American Independent Network cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signed ____ Date ____________________

Name (please print) ____

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/legal representative's name ____

Relationship to applicant/insured ____

Basis for representation (POA, guardian, etc.) ______________________________________
PLEASE ATTACH COPY OF LEGAL DOCUMENT