

AUTHORIZATION FOR THE RELEASE OF INFORMATION

RELEASE OF MEDICAL INFORMATION (HIPAA Compliant)

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically-related facility, insurance support organization, pharmacy, or any other institution or person (“Authorized Discloser”) to provide P&T Financial Co. or its designee (“Authorized Recipient”), any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, information relating to HIV or AIDS tests, or drug or alcohol abuse as it relates to me (hereinafter, “Protected Health Information” or “PHI”).

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data regarding the care and treatment of the patient, and any other PHI concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the patient, along with any and all medical charts, clinical or doctor’s notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in the possession and control of the Authorized Discloser.

By signing below, I understand that this Authorization shall apply to any and all PHI, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations. I further understand that PHI obtained may be used to evaluate eligibility to participate in Purchaser’s life settlement program and to evaluate life expectancy now and in the future. Authorized Discloser, however, may not condition treatment, payment, enrollment or eligibility for benefits upon this Authorization.

I agree that this Authorization is valid for six (6) months from the date thereof, and that a photocopy or facsimile is as valid as an original.

I understand that I may revoke this Authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser of the revocation in writing and delivering such revocation by certified mail or personal delivery at such address designated by the respective Authorized Discloser.

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 the Health Insurance Portability and Accountability Act of 1996 (the “HIPAA Privacy Regulations”), and that PHI obtained by this Authorization, if redisclosed by authorized Designee, may no longer be protected by the HIPAA Privacy Regulations.

Signature of Insured

Printed Name of Insured

Date Signed

Social Security Number

Signature of Witness

Printed Name of Witness

Date Signed