Claim No. :
Claimant's Name :

Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my medical information (also known as protected health information) as described below;

1. I, _____, Social Security Number _____ and date of birth _____, authorize all persons or entities that provided medial treatment to me to disclose the following medical information in your possession to **FFVA Mutual,** its employees, agents, subcontractors and authorized representatives ("FFVA Mutual").

2. Please provide **FFVA Mutual** with any and all information in your possession concerning my physical condition, past present and future, including but not limited to, healthcare history, diagnosis, condition, treatment or evaluation and other medical information do that they must use it or disclose it to evaluate, administer and resolve my claim related to injuries I received on (date of accident) _____. I understand that the medical information that is disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This authorization may be in force and effective until my claim related injuries I received on (date of accident)_____ is resolved, at which time this authorization to use or disclose this protected health information expires. I understand that I may revoke this authorization by notifying your adjuster in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by **FFVA Mutual** or the Releasing party in reliance on it before I revoked it.

4. As the person signing this Authorization for Release of Protected Health Information, I understand that I am giving permission to **FFVA Mutual** to obtain and use protected health information. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

A copy of this authorization may be accepted with the same authority as the original.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative