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The Standard Life Insurance Company of New York

855.WPP.PROG (855.977.7764)
PO Box 5031 White Plains NY 10602-5031

Authorization to Obtain and Release Health Information Workplace Possibilities Program

I authorize any health provider, employer, hospital, clinic, pharmacy, or counselor having any records or knowledge of me or my health to discuss with or disclose the following information to THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK (The Standard) for the purposes of evaluating and processing my Workplace Possibilities Service Request:

(Please initial by the type of information to be released/disclosed):

_____ My entire medical record (from _____ to _____)

_____ Information regarding specific condition (specify) _____

_____ X-Ray (films and reports)

_____ Laboratory results

_____ HIV test results (from _____ to _____)

_____ Mental health records (from _____ to _____), excluding psychotherapy notes

_____ Alcohol/Drug (from _____ to _____)

_____ Other (specify) _____

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization. I instruct the persons/organizations identified above to disclose the information selected above without restriction.
- I have the right to refuse to sign, and a right to revoke, this authorization at any time by sending a written statement to The Standard, except to the extent the authorization has been relied upon to disclose requested information and records. A revocation of, or the failure to sign, the authorization may impair The Standard's ability to evaluate or process my Workplace Possibilities Service Request.
- I understand that in the course of conducting its business The Standard may disclose information to any person performing services for them and to my employer regarding my Workplace Possibilities Service Request.
- I understand that the information disclosed to The Standard pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by federal or state law. Information retained and disclosed by The Standard may not be protected under the Health Insurance Portability and Accountability Act (HIPAA).
- I understand and agree that this authorization is valid for 12 months from the date signed below.
- A copy or fax of this authorization is valid as an original and will be provided to me upon request.

Name (please print) _____

Signature of Employee/Representative_____ Date _____

Please fax completed form to: 971-321-5727/855-207-6115

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