PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient:_____
(First Name) (Middle Initial) (Last Name)

Address:_____

Date of Birth:_____

Social Security Number:_____

_____, is authorized to furnish to:

Recipient: Atlantic Charter Insurance Company, 25 New Chardon Street, Boston, MA 02114

Purpose: Insurance

MEDICAL RECORDS (Excluding Sensitive Information)

Check one:

__ Information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with my condition or disease beginning ALL RECORDS and ending ALL RECORDS and, if necessary, allow them or any physician appointed by them to examine any x-rays or other diagnostic records which the facility may have regarding my condition or treatment during this period.

__ Only those records as described below:

ALL RECORDS from _____ to _____

SENSITIVE INFORMATION

In addition, I hereby specifically consent to the disclosure and release of "sensitive medical information" concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug abuse/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, **if any.**

I release _____ from any responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving notification to Atlantic Charter Insurance Company, provided that I do so in writing and to the extent that they have already disclosed the information in reliance on this authorization.

This authorization expires on _____ (Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

_____ _____
Patient Signature (Parent's Representative if Minor) Date

_____ _____
Witness Signature Date