AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I, _____, ID No._____,
(please print)
hereby authorize **Golden Rule Insurance Company** to disclose my personal information as described below.

Description of Information to Be Disclosed (please check all that apply):

- ☐ Medical Information (including claims information)
- ☐ All Non-medical Information (including financial information)
- ☐ Both Medical and Non-medical information (In the event that all boxes are left unchecked, both medical and non-medical information will be disclosed.)
- ☑ PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Purpose: FOR DISCOVERY BEFORE TRIAL

Person or Business Authorized to Receive Information:

Name: Record Deposition Services PH: (248) 357-3330 FAX (248) 357-3337

Address: 27355 W. Eleven Mile Road, P.O. Box 5054

Address: Southfield, MI 48086

Expiration of Authorization:

This authorization will expire 24 months from the date of your signature. (Only valid for one year in Connecticut, Georgia, Illinois, Massachusetts, Minnesota, North Carolina, New Jersey, Ohio, and Oregon.)

Your Signature:

_____ _____

Signature **Date**

YOUR RIGHTS

- I understand that I may revoke this authorization at any time prior to its expiration date by notifying Golden Rule Insurance Company (attn: Legal Department) in writing, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health information that the entity took before it received the revocation.
- I am not required to sign this authorization to become eligible for coverage or to receive my health care benefits.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by the federal privacy law regulating health insurers (45 CFR Parts 160 and 164 et seq.)
- I am entitled to a copy of this authorization form.

ATTN MAIL ROOM: ROUTE TO LEGAL SERVICES DEPT.