AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

1. I, _____, authorize Old Surety Life Insurance Company ("Old Surety") to disclose my protected health information to the following named individuals:
(No need to list providers below.)

   (Spouse)_____

   (Children)_____

   _____

   (Others)_____

2. _____ By initialing next to this paragraph, I also give the people listed above permission to make changes to my contact and billing information. I understand that all other changes must be made pursuant to a medical power of attorney.

3. This authorization is intended to provide the authorization necessary to allow Old Surety to disclose protected health information regarding me to the persons described above.

4. Information disclosed by a health care provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the privacy rules of 45 CFR § 164.

5. This authorization may be revoked by a writing signed by me or by my personal representative.

6. This authorization shall be valid at any time during my life and shall expire five years after my death unless validly revoked prior to that date.

SIGNED:

_____ _____
Insured's Signature Printed Name

DATED: _____ Policy #_____

[NOTARY NOT REQUIRED UNDER HIPAA]