Independent Financial Solutions, Inc.

Toll Free: (877) FIN-REPS
Fax: (732) 919-3156

750 Route 34
Suite 7
Matawan, NJ 07747

Proposed Insured:_____ **Social Security #:**_____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

(This authorization complies with HIPAA Privacy Rules)
Provide a signed copy to the Proposed Insured

This authorization will permit Independent Financial Solutions, Inc. (IFS), to obtain and release nonpublic personal information about me, the proposed insured, for the purpose of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or institutions ("the companies") listed below. Information that may be released and disclosed by IFS and the companies listed below pursuant to this authorization shall include any and all information, to the extent permitted by applicable law.

Information to be released pursuant to this authorization includes any personal health information, records or data concerning my past, present or future mental, physical, or behavioral health or condition ("Information"), to the extent permitted by law. "Information" includes all information, records, or data relating to my: physical or mental history or condition, medical treatment diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances, occupation, avocation, including any hazardous hobbies, driving records, aviation activities, and other personal traits.

I do understand that this information may include results from blood, saliva, urine, and other tests. I further understand that this information may, if applicable, include information regarding diagnosis, prognosis, and treatment of; alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2), serious communicable disease or infection, including sexually transmitted diseases, HIV Infection, including medical test results.

I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, medical testing laboratory, pharmacy, pharmacy benefit manager, medical facility, medical examiner, interviewer, insurance company, insurance support organization (such as MIB, Inc.) or other Health Care provider that has provided, payment, treatment or services to me or on my behalf ("My Providers"), consumer reporting agency, and any State Motor Vehicle Department to disclose the entire medical records and any other protected health information (including psycho therapy treatment) concerning me or about me to IFS, the companies listed below, their agents, employees, affiliates, and third party representatives. I also authorize the MIB to release information directly to any company, provided the insurer is a member of the MIB.

I understand that the information disclosed to IFS may have been subject to state and federal privacy laws and regulations. Once information is disclosed to IFS, it may no longer be subject to those laws and regulations. I do understand that I may refuse to sign this authorization to release my complete medical records, and in doing so, IFS and its representatives and companies listed below may not be able to process my request.

A photocopy of this authorization form shall be valid as the original. This authorization shall remain in force for 24 months following the date of my signature below, unless revoked by me in writing prior and written notice is provided to Independent Financial Solutions, Inc. (IFS) 750 Route 34, Suite 7, Matawan, NJ 07747. Alternatively, I may revoke this authorization by sending a written revocation directly to my providers. Any action taken prior to the notice of revocation shall be valid.

I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured or Authorized Representative — Date

_____
If signed by "Authorized Representative," describe authority (i.e. parent of a minor child) and relationship to the Proposed Insured

_____ _____
Printed Name of Proposed Insured & Social Security # — Date

_____ _____
Address of Proposed Insured — Date of Birth

_____ _____
Printed Name of Agent / Agent Signature — Date

Acacia	AXA/Equitable	ING	National Integrity	Security Mutual
All State	Banner Life	Jackson National Life	North American	Sun Life/Keyport
Allianz	Cavalier	John Hancock	Ohio National	Symetra
American Equity	Equitrust	Life of South West	Old Mutual/F&G	Independent Financial (IFS)
American Investors	Fidelity Life	Lincoln Benefit Life	Pacific Life	TransAmerica
American Memorial	Foresters	Lincoln National/Lincoln Financial	Penn Mutual	UNIFI Companies
American National	Forethought	Med America	Presidential Life	Union Central
American General	Gen Worth	MetLife	Principal Financial	United Home Life
Americo	GILICO	Midland National Life	Prudential	US Life
Ameritas	Great American	Minnesota Life/Securian	Reliastar	West Coast/Protective Life
Assurity	Guardian	Mutual of Omaha	Royal Bank of Canada	Western Life
Aviva	Guggenheim	Mutual Trust	SBLI	
	Hartford			