Authorization for Release of Health-Related Information

○ **Genworth Life and Annuity Insurance Company**
P.O. Box 320 • Lynchburg, VA 24505-0320

○ **Genworth Life Insurance Company**
P.O. Box 461 • Lynchburg, VA 24505-0461

This authorization complies with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)	Date of birth

Authorization

This Authorization for Release of Health-Related Information to the Life Insurer

Life Insurer

Genworth Life and Annuity Insurance Company, or Genworth Life Insurance Company, as shown above

Protected Health Information

Protected Health Information is my entire medical record and other health information. It includes information such as: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, sexually transmitted diseases and mental illness; prescription drug use; other insurance coverage; hazardous activities; character; and the use of alcohol, drugs, and tobacco. It excludes psychotherapy notes.

My Providers

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy database; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurer and its agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the Life Insurer.

This Authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that:1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Life Insurer at 3100 Albert Langford Drive, Lynchburg, VA 24501, Attention: Privacy Official; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurer has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be redisclosed and no longer covered by the federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the Life Insurer may not be able to perform the underwriting necessary to process my life insurance application. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Patient or Personal Representative	Date

Description of Personal Representative's Authority or Relationship to Patient