Manulife New York

HIPAA Compliant Authorization for Release of Health-Related Information

The Manufacturers Life Insurance Company of New York

(hereinafter referred to as The Company or Manulife New York)

Mailing Address:
Manulife New York
New Business Service Center
PO Box 4608
Niagara Square Station
Buffalo NY 14240-4608

Courier Address:
Manulife New York
New Business Service Center
200 Bloor Street East
Toronto ON
Canada M4W 1E5

Policy No. (for Internal Use Only)

Name of Proposed Insured/Patient (Please type or print)

First | Middle | Last

Date of Birth

mmm | dd | yyyy

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to The Manufacturers Life Insurance Company of New York (The Company). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that The Company 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 fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the Chief Underwriter, Manulife New York, New Business Service Center, 200 Bloor Street East, Toronto, Ontario, Canada M4W 1E5. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by The Company except as authorized by me or as required by law.

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 complete medical record, The Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request

Signed at City State | This | Day of | Year

Signature of Proposed Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

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