American Century Life Insurance Company
1333 W. McDermott Dr. #200
Allen, TX 75013
Phone (855) 966-1111
Fax (855) 855-0181

Authorization for Release of Medical Records

Authorization for: ☒ Disclosure ☐ Inspection ☐ Amendment of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

I hereby authorize the medical professionals and facilities listed below to release my records from the following facilities (list all facilities from which the insured received medical services from the date of the application for insurance with us):

Dr. Name	Facility Name	Address	Phone
1.			
2.			
3.			
4.			

Release to: (please provide names/address of persons/organization to which disclosure is to be made)
American Century Life Insurance Company
1333 W. McDermott Dr. #200
Allen, TX 75093
Phone: (855) 966-1111, Fax: (855) 855-0181

Date of Service to be released: _____

For the following purpose: ☐ Medical Care ☐ Legal ☒ Insurance

Select Portions of Protected Health Information authorized to release

☐ Abstract/Pertinent Information	☐ Lab	☐ Emergency Room	☐ MD Progress Notes
☐ Cardiac Studies	☐ H & P	☐ Consultation Report	☐ Face Sheet
☐ Operative/Procedure Report	☐ CPT Codes	☐ Itemized Bill	☐ Radiology
☐ Admit/Discharge Summary	☐ Radiology Reports	☐ Digital Images	

☐ Other: _____

☒ ENTIRE RECORD

EXCLUSIONS: _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of the Doctors' offices and facilities listed above to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

Date	**Signature of Patient/Parent/Conservator/Guardian**	**Authority/Relationship to Patient**