Authorization for Release of Information – HIPAA Compliant

(Excluding Psychotherapy Notes)

To be signed, dated and returned by the insured/claimant.

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
P.O. Box 7003
Indianapolis, IN 46207
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
Disability.claims@oneamerica.com

ONEAMERICA®

Claimant Name:	Claimant Date of Birth:
Claim Number:	Employer Name and Policy Number:

I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to American United Life Insurance Company® (AUL) and AUL's reinsurer(s) excluding psychotherapy notes and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Attn: Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. However, such revocation is not effective to the extent that AUL or AUL's reinsurer(s) have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of, or my failure to sign this authorization may impair AUL's ability to evaluate my current disability claim and as a result, lack of required information may be a basis for denying that current disability claim for benefits.

If you reside in **California, Connecticut, Maine, or Massachusetts: This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING AUL to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and AUL shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)

G-27041 7/16/19