Lincoln Financial Group®

The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Authorization for Release of Information

_____ /_____ /_____ /_____
Proposed Insured/Patient: *(First)* *(Middle)* *(Last)* *(Suffix)*

Date of Birth (MM/DD/YYYY): _____ /_____ /_____

I (the undersigned) authorize any licensed physician, medical practitioner, nurse, records custodians, hospital, clinic, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge about me or my health, including but not limited to complete medical records in paper or electronic format, (including information regarding insurance, referral documents and records from other facilities) to give all such information to the Company, their licensed representatives, their reinsurers, and/or approved vendors.

I understand that:

- information released may include information obtained through my telephonic or Personal Health Interview(s) and include information regarding my physical and mental health and my insurance policies and claims, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding testing, diagnosis, presence and/or treatment of communicable diseases to include, Human Immunodeficiency Virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS).
- an Authorization for Release or disclosure of psychotherapy notes may not be combined with an Authorization for Release or disclosure of any other information (a separate Authorization must be completed for release or disclosure of psychotherapy notes).
- I am authorizing the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc.
- the information obtained may be used by the Company to determine eligibility for insurance, for analysis to enhance our products and services or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; 3) any other person or entity who performs business or legal services in connection with the application for or administration of my insurance coverage; 4) the agent and/or agency; or 5) any person or entity who conducts other legally permissible activities that relate to any coverage I have, or have applied for with the Company. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.
- this consent may be revoked in writing to the address above, at any time, except to the extent: 1) the Company has previously taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim regarding my policy. If written revocation is not received, this Authorization will be considered valid for 24 months from the date of signing and I agree that a copy of this Authorization shall be as valid as the original and that I may have a copy upon request.
- there is a possibility of re-disclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
- the entries made in the Vendor Use box below do not alter this Authorization.
- I do not have to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).
- if I refuse to sign this Authorization to release my complete medical records in paper or electronic format, that medical treatment cannot be withheld. If I refuse to sign this Authorization, the Company may not be able to process my application for insurance.

_____ _____ /_____ /_____
Signature Date (MM/DD/YYYY)

Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient:

_____

For Vendor Use Only

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