



### Prescription History Authorization

I, the undersigned Designated Person, or his or her authorized representative, both referred to as ("I") in this document

Designated Person's Name: \_\_\_\_\_  
First Middle Last

Other Names Used: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

hereby authorizes any and all medical practitioners, physicians, pharmacists, pharmacy benefits managers, health care clearing houses, hospital, clinics, nurses, or records custodians to release any and all records and information within their possession, custody or control, regarding my/the Designated Person's diagnosis, testing, treatment and prognosis, including any information and records regarding my/the Designated Person's physical or mental condition, and including, but not limited to, records and information concerning my/the Designated Person's: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's as follows:

Such information and records may be released to and exchanged between the insurance company and the Other Party listed below, as well as the Insurer's and the Other Party's agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

**Insurer**  
Colorado Bankers Life Insurance Company  
5990 Greenwood Plaza Blvd  
Suite 325  
Greenwood Village, Colorado 80111

**Other Party**  
EMSI  
P.O. Box 2505  
Waco, Texas 76702-2505

The purpose of this disclosure is to evaluate my/the Designated Person's application for insurance or claim benefits.

I understand that when my/the Designated Person's medical records are disclosed pursuant to this Authorization, I/the Designated Person's medical records and the information contained in those records may become subject to further disclosure by the insurance company. For example, the insurance company may be required to provide such information to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. This Authorization will remain in effect a maximum of six (6) months from the date of signature below. I understand I may revoke this Authorization as to the Insurer and/or the Other Party at any time, by requesting such action of the Insurer and/or the Other Party to whom such revocation is to apply, in writing at their address stated above, unless action has already been taken in reliance upon this Authorization, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this authorization to release my/the Designated Person's complete medical records, my/the Designated Person's insurance company may not be able to process my/the Designated Person's application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

Signature of Designated Person/guardian/ personal representative: \_\_\_\_\_ Date: \_\_\_\_\_

Legal relationship to applicant: \_\_\_\_\_  
(Only if signed above by guardian or personal representative)