ashar group
LIFE SETTLEMENTS & LIFE INSURANCE VALUATION

hipaa

I, _____ (the undersigned individual), DOB_____SS#_____, hereby authorize disclosure, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, of my protected health information ("PHI") as follows:

1. **Classes of Persons Authorized to Disclose My PHI**. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory, pharmacy benefits manager, health care professional or clinician, insurance organization and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization. This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding my care and treatment and any other information in any Authorized HCP's possession concerning any treatment or hospitalization.
2. **Classes of Persons Authorized to Receive My PHI**. I authorize each Authorized HCP to disclose my PHI under this authorization to Ashar Group, LLC including a) any of its affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each; and b) to any other person or entity required or compelled by law to receive or view such PHI to evaluate, monitor, facilitate, underwrite, solicit bids and/or complete the sale of my life insurance policy(ies), including but not limited to medical underwriters, lenders, financing entities, brokers/brokerages, buyers of life insurance policies, life expectancy providers and stop-loss re-insurers and its or their affiliates, agents, subsidiaries, corporate parents, independent contractors, consultants, service providers and authorized representatives and the officers, directors and employees of each (each, an "Authorized Recipient"). I understand that my PHI may be secured by and electronically transmitted to an Authorized Recipient, including but not limited to transmission via e-mail and posting to a password protected, secure website.
3. **Description of PHI Authorized for Disclosure and Purpose of Disclosure**. This authorization shall apply to any and all of my health and medical data, evaluations, notes, treatments, prescriptions, laboratory results, diagnosis, information, recommendations, reports and records (collectively, "Data"), whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing an Authorized Recipient to (1) analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured; and (2) monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that an Authorized Recipient, or any other person or entity, evaluates and/or purchases. In addition, I acknowledge that some state and federal laws prohibit or may prohibit the further disclosure of Data related to mental health, substance abuse (drugs, alcohol, medications or other) or HIV related and/or communicable disease information without specific written consent. This authorization shall serve as specific consent in order for a) such disclosure to occur; and b) each Authorized Recipient to perform the functions described herein.
4. **Expiration of Authorization**. This authorization shall remain valid until, and shall expire, one year after the date of my death or the maximum period as allowed by state or federal law.
5. **Right to Revoke Authorization** – Ashar Group, LLC. I acknowledge and understand that I may revoke this authorization any time with respect to Ashar Group, LLC by notifying Ashar Group, LLC in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at: [1800 Pembrook Drive, Suite 240, Orlando, FL 32810]; provided, that, any revocation of this authorization shall not apply to the extent that Ashar Group, LLC has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
6. **Inability to Condition Treatment**, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that a) this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"); b) as a result of this Authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to re-disclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations; and c) my ongoing health status may be tracked as a result of this Authorization.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Authorized by:

_____ _____

SIGNATURE OF **INSURED** Date SIGNATURE OF **LEGAL REPRESENTATIVE** (if any) Date

PRINTED NAME:_____ PRINTED NAME:_____ _____

DESCRIPTION OF LEGAL REPRESENTATIVE'S AUTHORITY (if any):_____
(POA, GUARDIAN AD LITEM OR SIMILAR STATUS–PLEASE ATTACH LEGAL DOCUMENT FOR VERIFICATION)

Viator's/ Owner 1 Initials: _____

policyservices@ashargroup.com

Viator's/ Owner 2 Initials: _____