AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	**This form is HIPAA Compliant**

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies list below, Advantage Insurance Network, Trusted Advisors Network,LLC, McReynolds & Associates, RMF Financial, M. Williamson Insurance Services and, brokers, contractors, employees, representative and agents working through Trusted Advisor Network for the Proposed Insured applying for or evaluating insurance coverage

Insurance Companies and Agencies

Advantage Insurance Network, Inc.	Fidelity & Guaranty Life Ins. Co.	Metropolitan Life	Reliastar Standard
Accordia Life & Annuity	First Global Financial & Insurance	MetLife Investors USA Ins. Co.	Reliance Standard
Allianz	First Insurance Funding	Minnesota Life/Securian	RMF Financial Inc, Robert
American General Life (AIG)	First Penn	M. Williamson Insurance Services	Friedman
American National Ins. Company	FFR	Mutual of Omaha	RSA Medical
Ameriican-Amicable	Foresters	National Life of Vermont	Royal Neighbors of America
Americo	General American Life Ins. Co.	National Western	Savings Bank Life Insurance
Assurity Life	Global Atlantic Financial Group	Nationwide Life & Annuity Co.	SBLI
Atlantic Insurance Brokerage	Global Insurance Underwriters	New Investor World, Inc.	Security Mutual
Aviva/Indianapolis Life/ Accordia	GE Financial Assurance Co.	New York Life Insurance Co.	Standard Life
Ameritas	Genworth Life Insurance Co.	North American Co.	Superior Medical Group
APPS Para Medical Services	Genworth Life and Annuity	Old Mutual	Symetra Financial
AVS, LLC	Guardian Life Ins. Co	One America/ State Life	Transamerica Life Ins. Co.
AUS Underwriting	Illinois Mutual	Pan America	Travelers Life & Annuity
AXA/MONY/AXA Equitable	ING – ReliaStar	Pacific Life	Trusted Advisor Network, LLC
Brighthouse Life Ins. Company	John Hancock Life Ins. Co.	Penn Mutual	21st Services
Banner Life	John Hancock USA	Premium Funding Group (PFG)	Union Central Life
AIN Member Firm	Lafayette Life	Pioneer Mutual	United of Omaha
Cavalier & Associates	Life Insurance of the Southwest	Portamedic	USG Annuity & Life
Columbus Life	Life Settlement Settlements, Inc	Presidential Life	US Life in the City of NY
Concord Capital/INSCAP	LifeShare	Principal Life Insurance Company	West Coast Life Insurance Co.
Coventry First, LLC	Lincoln Financial/Lincoln Life	Principal National Life Ins. Co.	Western Reserve Life
EMSI	Lincoln National Life Ins. Co.	Producer Resources Inc.	William Penn Life Ins. Co.
Equity Key, LLC	Lloyds of London	Professional Underwriting Services	Zurich American Life Ins. Co.
Equity Release	Massachusetts Mutual	Protective Life Ins. Co	
	McReynolds & Associates. Inc.	Prudential Life Ins. Co/ Pruco Life	

Additional Insurers and Agencies: **Broker/Agent/Financial Professional:** **Michael J McReynolds CLU, ChFC**

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be release may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3)pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use the information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,
Physician Name(s): _____

Physician Address: _____
any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to Producer Resources, Inc. and Atlantic Insurance Brokerage, the Insurers and Agencies listed afore and to:
Agent/Producer Name: _____
I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (1) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected ma be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applies in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signature of Proposed Insured/Guardian or Custodian/Authorized Representative

X_____ Printed Name: _____

Date: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE