PHOENIX®
Phoenix Life Insurance Company (Phoenix)
PHL Variable Insurance Company (Phoenix)
One American Row, PO Box 5056, Hartford CT 06102-5056

HIPAA Authorization to Release Medical Information

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Phoenix Life Insurance Company (Phoenix) or its subsidiaries, its agents, employees, and representatives. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This authorization allows release of information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, but excludes the release of information about HIV (AIDS virus) tests administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider to release and disclose my entire medical record without restriction, except as noted above

This protected health information is to be disclosed under this Authorization so that Phoenix may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage including riders, features, changes and reinstatements; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Phoenix.

This authorization shall remain in force for 26 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Phoenix at One American Row, Hartford, CT 06103-2899, Attention: Chief Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Phoenix has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal HIPAA rules governing privacy and confidentiality of health information. Phoenix maintains full compliance with applicable federal and state privacy rules. A copy of the Phoenix privacy policy is available upon request.

I understand that if I refuse to sign this authorization to release my complete medical record, Phoenix may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Name of Authorizing Party/Insured (please print) Date of Birth

_____ _____
Signature of Authorizing Party/Owner Date

_____
Description of Personal Representative's Authority or Relationship to Authorizing Party