

# AUTHORIZATION TO RELEASE INFORMATION

- ReliaStar Life Insurance Company, Minneapolis, MN
- ReliaStar Life Insurance Company of New York, Woodbury, NY
- Security Life of Denver Insurance Company, Denver, CO
- Midwestern United Life Insurance Company, Fort Wayne, IN
- Voya Insurance and Annuity Company, Des Moines, IA



A member of the Voya family of companies  
("the Company")

Voya Life Claims: PO Box 1548, Minneapolis, MN 55440, Phone: 888-238-4840 (toll free)

Insured/Patient Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Policy Number \_\_\_\_\_

This is an employer-sponsored plans, please provide employment information as of the date of application.

Employee Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Phone (\_\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_

In the boxes below list:

- the Insured's primary care physician from \_\_\_\_\_ to \_\_\_\_\_
- all hospitals, clinics or institutions where the Insured was treated at from \_\_\_\_\_ to \_\_\_\_\_
- all pharmacies where the insured received prescriptions from \_\_\_\_\_ to \_\_\_\_\_

Name	Complete Mailing Address	Phone Number	Fax Number

YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.  
IMPORTANT! SIGNATURE REQUIREMENT ON PAGE 2.

Insured/Patient Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Policy Number \_\_\_\_\_

I authorize release of the following information:

- |  |   |
|--|---|
| <input type="checkbox"/> Abstract (The Abstract includes)* | <input type="checkbox"/> HIV/AIDS Testing & Treatment     |
| History & Physical Exams*                                  | <input type="checkbox"/> Laboratory Reports               |
| Operative Reports*   | <input type="checkbox"/> Employment Records               |
| Discharge Summaries*                                       | <input type="checkbox"/> Police and Accident Reports      |
| EKG/Cardiovascular*  | <input type="checkbox"/> Medical Examiner/Coroner Reports |
| Substance Abuse*   | <input type="checkbox"/> Other _____                      |
| Mental Health*   |   |
| Emergency Medicine Reports*                                |   |
| Office Notes*  |   |
| Consultations/Evaluations*                                 |   |
| Diagnostic Reports*  |   |

**Collection of Information:** In order to evaluate or administer claims for benefits, we must collect information about the insured. The type of information that we may collect includes, but is not limited to, the following examples: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information, including earnings and other employment-related information; accident, incident, or police reports; medical examiner and coroner reports. The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically-related facilities, insurance or reinsuring companies, MIB, Inc., employer or group policy owners, contract holders, benefit plan administrators, and any other organizations.

**Acknowledgement:** I acknowledge these statements:

- I understand that I may revoke this Authorization at any time by sending a written request to Voya. Such revocation will not have any effect on any action taken by Voya and its' affiliates prior to the revocation.
- This authorization will expire one (1) year from the date of signature or when revoked or on the following date \_\_\_\_\_
- I understand that this information may include information relating to: (a) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, (b) Mental or behavioral health or psychiatric care, (c) Treatment of drug or alcohol abuse.
- I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
- This information will be used/disclosed for insurance claim determination.
- I understand that a photocopy of this Authorization will be as valid as the original.

 Signature \_\_\_\_\_ Date \_\_\_\_\_

If signed by someone other than the insured, indicate relationship.

- Legal Guardian\*    Estate Representative\*    Health Care Power of Attorney\*  
 Self    Parent    Spouse    Next of Kin    Beneficiary    Other \_\_\_\_\_

\*If signed by a Legal Representative attach appropriate documentation to verify authority.