Authorization for Release of Health-Related Information to
Crescent Life Settlements, Hancock Brokerage LLC and Its Carriers

This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____

Name of proposed insured/patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, insurance company, insurance support organization, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Crescent Life Settlements LLC and Hancock Brokerage LLC ("the Company") and its agents, employees, representatives and carriers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy, notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under the Authorization so that the Company may: 1(provide information to carriers so that carriers may underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 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 the Company at **Crescent Life Settlements, LLC, 900 Veterans Memorial Blvd., Metairie, LA 70005, Attention: HIPPAA Privacy Official.** Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers, I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). I understand that if I refuse to sign this authorization, the Company 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.

_____**Date**_____

Signature of **Proposed Insured/Patient** or Personal Representative

_____**Date**_____

Signature of **Secondary Proposed Insured/Patient** or Personal Representative

_____**Date**_____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

SS# of Primary Insured/Patient:_____-____-_____SS# of Secondary Insured/Patient: _____-____-_____

Address:_____ Address:_____

_____

Abacus	Equitable	Magna	Pacific Life	SBLI
AIG/American General	Genworth	Maple	Peterson International	Symetra
American National	Global Atlantic	Minnesota Life	Principal Life	Transamerica
Assurity	Guardian Life	National Life-LSW	Protective	United of Omaha
Banner Life/Legal	ILS	National Western	Prudential	Voya
Brighthouse (Met Life)	John Hancock	Nationwide	Q Captial	Life Settlement Providers
Cincinnati Life	Life Equity	North American	Sagicor	Crescent Life Settlements
Coventry	Lincoln Financial	One America		

Agent's Name:_____**Phone#**_____**Fax#**_____

E-MAIL:_____ ***Revised 6.5.20***