Senior Citizen Medical Record Authorization Release Form
(for Medicare Supplement Insurance)

1. Applicant Information

Full Name

Date of Birth

Social Security Number

Address

Phone Number

Email

2. Recipient of Information

Insurance Company Name

Insurance Company Address

3. Health Care Provider(s) Authorized to Disclose Information

4. Information to be Released

5. Purpose of Disclosure

6. Expiration Date or Event

Date or Event

Authorization:
I authorize the release and disclosure of my medical records and health information to the insurance company listed above for the purpose of underwriting and administering my Medicare Supplement Insurance application. I understand that this authorization is voluntary and that I may revoke it at any time in writing. I understand that information disclosed pursuant to this authorization may be subject to redisclosure.

Signature of Applicant

Date

If authorized representative, print name and relationship to applicant