Life Insurance Medical Information Release Form

Personal Information

Full Name

Date of Birth

Address

Phone Number

Authorization

I authorize (Name of Medical Provider or Facility)

to disclose my medical information to (Insurance Company Name)

Purpose of Disclosure

Information to be Released

Expiration & Revocation

This authorization expires on

I understand that I may revoke this authorization at any time by notifying the provider in writing.

Signature

Signature

Date