**AUTHORIZATION FOR RELEASE OF INSURANCE RELATED PERSONAL INFORMATION**

I authorize AMA Insurance Agency, Inc., 330 N. Wabash Avenue, Suite 39300, Chicago, IL 60611-5885 ("Company") to disclose my personal insurance information as described in this Authorization.

**1. Insured's Information**

Name of Insured: _____

Date of Birth: _____

Address: _____

Certificate Number (s): _____

**2. Person or Entity Authorized to Receive Personal Insurance Information**

I authorize disclosure of my Personal Insurance Information to:

Name: _____

Address: _____

Email: _____

**3. Information Covered**

This Authorization applies to personal insurance information, including but not limited to:

- Identifying information (such as name, address, date of birth)
- Policy and coverage information
- Premium, billing, and payment information
- Claims information (excluding medical records)
- Underwriting and eligibility information
- Loss history and risk-related data

This Authorization does **NOT** apply to:

- Protected Health Information (PHI) governed by HIPAA
- Any information requiring a HIPAA-compliant authorization

**4. Purpose of Disclosure**

The purpose of this disclosure is (check one):

☐ At my request

☐ Care coordination or case management

☐ Other (specify): _____

**5. Expiration of Authorization**

This Authorization will expire on (check one):

☐ A specific date: _____

☐ Upon the occurrence of the following event: _____

☐ One (1) year from the date of my signature

**8. Right to Revoke**

I understand that I may revoke this Authorization at any time by providing written notice to the insurance company listed above, except to the extent that action has already been taken in reliance on this Authorization.

**9. Redisclosure Notice**

I understand that information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy laws.

**10. No Conditioning**

I understand that signing this Authorization is voluntary and that my treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this Authorization, except as permitted by law.

**11. Signature**

I certify that I have read and understand this Authorization, and I authorize the disclosure of my Personal Insurance Information as described above.

**Signature of Insured or Personal Representative:** _____

**Printed Name:** _____

**Date:** _____

If signed by a personal representative, describe authority to act on behalf of the individual (e.g., parent, legal guardian, power of attorney) and attach authorizing documents:

---

---