AUTHORIZATION FOR RELEASE OF INSURANCE CLAIM INFORMATION

HIPAA COMPLIANT - LIMITED PURPOSE AUTHORIZATION

Date: [Date]

POLICYHOLDER INFORMATION

Name: [Insured Name]
Date of Birth: [DOB]
Social Security #: XXX-XX-[Last 4]
Driver's License #: [Number] State: [State]
Policy Number: [Policy #]
Claim Number: [Claim #]
Date of Loss: [Date of Loss]
Loss Location: [Property Address]

AUTHORIZATION SCOPE

TO WHOM IT MAY CONCERN:

I, [Insured Name], hereby authorize and direct any and all of the following parties to release, disclose, provide copies of, and discuss any and all information, records, documents, reports, communications, and data (electronic or physical) relating to my insurance claim referenced above to:

PRIMARY AUTHORIZED RECIPIENT:
[Insurance Carrier Name]
ATTN: [Adjuster Name] - Adjuster License #: [Number]
[Address]
[Phone] | [Fax] | [Email]

ADDITIONAL AUTHORIZED RECIPIENTS:
☐ Mortgage Company: [Name], Attn: [Department]
☐ Public Adjuster: [Name], License #: [Number]
☐ Attorney: [Name], Bar #: [Number]
☐ Contractor: [Company Name], License #: [Number]
☐ Other: [Name/Relationship]

ENTITIES AUTHORIZED TO RELEASE INFORMATION

Government Agencies

- Law enforcement agencies (all responding departments)
- Fire departments and fire marshal offices
- Building/Code enforcement departments
- Health departments
- County/City permit offices
- Emergency management agencies
- Weather service/Meteorological agencies

Professional Services

- Engineers and structural consultants
- Environmental testing companies
- Restoration and mitigation contractors
- General contractors and subcontractors
- Architects and designers
- Public adjusters
- Private investigators
- Security companies

Utilities and Services

- Electric utility companies
- Gas utility companies
- Water/Sewer authorities
- Cable/Internet providers
- Telephone companies
- Alarm/Security monitoring services
- Waste management services

Financial Institutions

- Mortgage lenders/servicers
- Banks and credit unions

- Credit card companies (for purchase verification)
- Insurance companies (prior carriers)
- Escrow companies

Medical Providers *(if injury-related)*

- Hospitals and emergency rooms
- Physicians and specialists
- Urgent care facilities
- Ambulance/EMS services
- Physical therapy providers
- Pharmacies

Other Entities

- Property management companies
- Homeowners associations
- Employers (for ALE/lost income only)
- Storage facilities
- Moving companies
- Hotels/Temporary housing providers
- Previous/Current tenants
- Neighbors with relevant information

INFORMATION AUTHORIZED FOR RELEASE

Investigation Records

- Police reports, case files, and supplemental reports
- Fire investigation reports and origin/cause determinations
- Incident reports and witness statements
- Photos, videos, and body camera footage
- 911 call recordings and dispatch logs
- Evidence logs and chain of custody records
- Criminal investigation findings

Property Records

- Building permits and inspection records
- Code violation notices
- Property tax records and assessments
- Ownership and title documents
- Survey and plot plans
- Architectural plans and specifications
- Prior insurance claim history

Service Records

- Utility service records and outage reports
- Maintenance and repair records
- Alarm system activation logs
- Equipment service history
- Contractor estimates and invoices
- Warranty and service contracts

Financial Records *(Limited to claim-relevant information)*

- Proof of ownership/purchase receipts
- Credit card statements (for damaged items)
- Bank statements (for purchase verification)
- Mortgage payment history
- Property tax payments
- Income verification (for ALE only)

Communications

- Emails, text messages, voicemails related to the loss
- Work orders and service requests
- Correspondence regarding property condition
- Insurance-related communications
- Social media posts relevant to claim

Medical Records *(If applicable)*

- Emergency treatment records

- Diagnostic test results
- Physician notes and discharge summaries
- Billing records for treatment
- Prescription records
- Disability/Work status reports

SPECIFIC EXCLUSIONS

This authorization does NOT include:

- Mental health/psychiatric records (unless specifically initialed here: ___)
- HIV/AIDS testing or treatment records
- Substance abuse treatment records
- Genetic testing information
- Records unrelated to this specific claim
- Information protected by attorney-client privilege

PURPOSE AND USE LIMITATIONS

This information is authorized for release SOLELY for the following purposes:

1. Investigation and evaluation of insurance claim #[Claim #]
2. Adjustment and settlement of said claim
3. Subrogation investigation and recovery
4. Defense of any coverage disputes
5. Compliance with policy conditions
6. Fraud investigation (if applicable)

This information may NOT be used for:

- Marketing or solicitation purposes
- Sale to third parties
- Unrelated insurance underwriting
- Credit reporting purposes
- Employment decisions
- Any purpose unrelated to this specific claim

DURATION AND REVOCATION

Effective Period:
This authorization is effective from [Date] and shall remain in effect for: ☐ One (1) year from the date signed
☐ Until final claim settlement
☐ Until [Specific Date]
☐ Other: [Specify duration]

Revocation Rights:
I understand that I may revoke this authorization at any time by providing written notice to [Insurance Carrier Name] at [Address], except to the extent that:

1. Action has already been taken in reliance upon this authorization
2. The insurance company has a legal right to contest the policy or claim

Revocation Procedure:
Written revocation must be sent via certified mail to the carrier's legal department and will be effective upon receipt.

ELECTRONIC RECORDS AND COMMUNICATIONS

I specifically authorize:
☐ Release of electronic records and data
☐ Email communication of protected information
☐ Electronic/digital signatures on releases
☐ Cloud storage access for relevant files
☐ Text message communications
☐ Encrypted file transfers

PHOTOCOPY/ELECTRONIC VERSION VALIDITY

A photocopy, scan, fax, or electronic version of this authorization shall be considered as valid as the original signed authorization.

HIPAA ACKNOWLEDGMENT

I understand that:

- Health information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA privacy regulations
- I have the right to receive a copy of this authorization

- I may refuse to sign this authorization, but it may affect my insurance claim processing
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization, except as permitted by law

RE-DISCLOSURE STATEMENT

Information released under this authorization may be protected by federal and state privacy laws. Re-disclosure of this information by the recipient may be prohibited without specific written consent.

INDEMNIFICATION

I agree to indemnify and hold harmless any person or entity who provides information in good faith reliance upon this authorization from any liability, claims, or damages arising from the release of the requested information.

FRAUD WARNING

I understand that any person who knowingly presents false information in connection with an insurance claim may be guilty of a crime and subject to fines and imprisonment.

CLAIM SPECIFIC INFORMATION

Claim Details for Reference:
Claim Number: [Claim #]
Date of Loss: [Date]
Type of Loss: [Fire/Water/Wind/Theft/Other]
Policy Number: [Policy #]
Property Address: [Address]
Adjuster: [Name]
Carrier Claim Phone: [Phone]

QUESTIONS AND CONTACT

For questions regarding this authorization or the information released:

Contact Person: [Name]
Title: [Title]
Phone: [Phone]
Email: [Email]
Hours: [Business Hours]

SIGNATURES

POLICYHOLDER:

I have read and understand this authorization. I am signing voluntarily and understand the implications of this release.

[Insured Name]
Signature: _____
Date: [Date]
Time: [Time]

Print Name: [Full Legal Name]
Relationship to Claim: ☐ Insured ☐ Authorized Representative

WITNESS #1:
Signature: _____
Print Name: [Name]
Date: [Date]

WITNESS #2 (if required):
Signature: _____
Print Name: [Name]
Date: [Date]

NOTARIZATION *(If required by state law or carrier)*

State of [State]
County of [County]

On this [Day] day of [Month], [Year], before me personally appeared [Insured Name], who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity.

Notary Public
Commission #: [Number]
My Commission Expires: [Date]

[Notary Seal]

FOR INSURANCE COMPANY USE ONLY:

Received by: _____ Date: _____ Time: _____

Method: ☐ Original ☐ Fax ☐ Email ☐ Mail

Logged into System: ☐ Yes Date: _____

Expiration Date Noted: _____
