PO BOX 25936
Overland Park, KS 66225
1-877-246-6997

Authorization to Release Information

I hereby authorize my health care providers to release information to Summit America Insurance Services for the purpose of facilitating the process and/or payment of claims on my behalf. I authorize release of information regarding medical, dental, mental, alcohol or drug abuse history or treatment, or any information necessary for the determination of benefits under my policy.

This authorization will be good for one year from the date of signature. I understand that I may revoke this authorization by providing a written request to Summit America at any time and this is valid for one of the original signed released. I further agree that a photo copy of this authorization shall be as valid as the original.

_______________________________________ ________________________________

Signature Date