



AUTHORIZATION FOR RELEASE OF RECORDS

TO: American National Insurance Company
Galveston, Texas 77550

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ SSN: _____

Daytime Telephone: _____

1. I authorize the use or disclosure of the above named individual's information as described below.
2. The following individual or organization is authorized to make the disclosure:

American National Insurance Company
Attn: Records Authorization
P.O. Box 1950
Galveston, Texas 77553

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

ANY AND ALL

4. Initial if applicable: _____. This authorization includes a request to release medical and health records. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization.

Name: MINUTE MAN SERVICES, INC.

Address: 3318 N MAIN ST

City: Royal Oak State: MI Zip: 48073

For the purpose of: LEGAL REVIEW

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the person or company identified in No. 2 above. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

1 YEAR FROM DATE SIGNED

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure. I understand that when information is disclosed pursuant to this request, it may not be protected by federal or state confidentiality rules.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Date: _____

Signature

Signature of witness

OR, if applicable – (attach copy of document conveying authority, e.g. notarized power of attorney, letters of guardianship or administration, etc.)

Signature of Guardian or Representative

Signature of witness

Description of Authority to Act for Personal Representative of Patient's Estate