PACIFIC LIFE
& ANNUITY COMPANY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Pacific Life & Annuity to disclose my individually identifiable health information as described below to:

_____

(NAME, ADDRESS AND PHONE NUMBER OF COMPANY OR PERSON)

I understand that this authorization is voluntary and that the information to be disclosed is protected by law. I also understand if I authorize the release of information to anyone other than a health plan or health care provider, the information may no longer be protected by the HIPAA Privacy Rule.

_____	_____	_____
Patient Name	Insured Person's I.D. Number (From the I.D. Card)	Date of Birth

Purpose of the disclosure (tell us the specific purpose[s] of the request; use back of form if necessary):

_____

_____

_____

Description of the information to be disclosed (e.g., claim history, eligibility information, etc.; use back of form if necessary):

_____

_____

If you want to exclude or limit the release of any specific information from your authorization, please indicate above. **NOTE**: An authorization for the release of psychotherapy notes cannot be combined with an authorization for any other purpose.

Important Information: By signing this authorization:

- I understand that my eligibility for Pacific Life & Annuity health benefits and payment for services covered by my Pacific Life & Annuity plan will not be affected if I do not sign this form.
- I understand that I should retain a copy of this signed authorization form and Pacific Life & Annuity will provide me a copy upon my request.
- It is my intent that this authorization remain in effect until all claims for services rendered while I am covered under my Pacific Life & Annuity plan are finalized.
- I understand if I sign this form, I may revoke my authorization at any time by notifying Pacific Life & Annuity in writing. But, if I do so, it won't have any effect on actions that Pacific Life & Annuity took before it received the notification.

_____	_____
Signature of patient or patient's legal representative	Date
_____	_____
Name of patient's legal representative, if applicable	Relationship to patient

Please complete, sign and return this form to:

Pacific Life & Annuity Company
P.O. Box 34799
Phoenix, AZ 85067-4799