Berkshire Life Insurance Company of America
Home Office: Pittsfield, Massachusetts
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888-505-8743

Berkshire Life Insurance Company of America, Pittsfield, MA is a wholly owned stock subsidiary of The Guardian Life Insurance Company of America, New York, NY

You have requested that we release your personal health information to a third party. In order for us to comply with your request, we will need your signed authorization. Please complete this form and return to us in the enclosed envelope.

AUTHORIZATION FOR DISCLOSURES OF PERSONAL HEALTH INFORMATION

I authorize the disclosure of personal health information about me as described below.

AUTHORIZATION REQUEST

This authorization was prepared (Check as applicable):

_____ At the request of the insured

_____ At the request of the insured's personal representative. Please describe representative's authority to act on insured's behalf:

_____

INFORMATION TO BE USED OR DISCLOSED

Describe fully the information that is the subject of this authorization and which will be disclosed as set forth below:

_____

_____

AUTHORIZATION FOR DISCLOSURE

Berkshire Life Insurance Company of America may release my personal health information which is described above to the following person(s) or group of persons:

_____

REDISCLOSURE OF INFORMATION

I understand that if the person or entity that receives information provided pursuant to this authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations.

REVOCATION OF AUTHORIZATION

As described in Berkshire Life Insurance Company of America's Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time by sending a written revocation to: Berkshire Life Insurance Company of America, Long Term Care Administrative Office, ATTN: Privacy Administrator, P.O. Box 4243, Woodland Hills, CA 91365-4243. I also understand that any such revocation will not be effective to the extent that action has been taken by the Company in reliance on this authorization or the extent that the Company has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This authorization will be valid for 24 months from the date of my signature below **or**:

_____

(Insert applicable date or specific event)

A copy of this authorization is as valid as the original.
I understand that I am not required to sign this authorization form and that Berkshire Life Insurance Company of America will not condition the provision of payment to me on the signing of this authorization.

Insured Name	Name of Personal Representative (if applicable)	Relationship of Personal Representative to Insured

_____ _____

Signature of Insured (or Insured's Personal Representative) Date