SUMMIT AMERICA
Insurance Services

Authorization to Disclose Information

Student Name: _____ Date of Birth:_____

School Name: _____ ID Number: _____

I authorize Summit America Insurance Services, LC to disclose information to the following person in relation to medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information.

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. I further agree that a photo copy of this authorization shall be as valid as the original.

_____ _____
Person to whom Summit America may disclose information Relationship

Please itemize any restrictions upon this release: _____

_____

_____

_____ _____
Student Signature Date

Return this form by mail or fax to:

Summit America Insurance Services
Attn: Claims Department
7400 College Blvd., Suite 100
Overland Park, KS 66210
Fax: (913) 327-7520