AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as follows:

A) Classes of Persons Authorized to Disclose My Protected Health Information: I hereby authorize each physician, doctor, physician practice group, nurse, hospital, and any other health care provider (each considered an "Authorized Discloser") to disclose any and all of my PHI as provided under this authorization. I further authorize each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this authorization. This authorization terminates any agreement I may have made with my health care provider(s) to restrict my PHI and I instruct my provider(s) to release and disclose my entire medical record without restriction.

B) Person Authorized to Receive My Protected Health Information: I authorize my PHI to be disclosed by each Authorized Discloser under this authorization to AVS Underwriting, LLC and any of its officers, partners, employees, agents, independent contractors or other representatives (collectively known as the "Authorized Recipient"). They may also disclose this information as allowed by law.

C) Description of Protected Health Information Authorized for Disclosure and the Purpose for Such Disclosure: This authorization shall apply to any and all of my PHI, including but not limited to, medical records, charts, laboratory reports, test results, or similar information or knowledge of me or my health condition, including but not limited to, PHI relating to AIDS/ARC/HIV, Alcohol and/or Drug Abuse, Mental Health and Communicable Diseases, whether or not personally identifiable or protected under any federal or state confidentiality or privacy law or regulations. This authorization and all disclosures of my PHI made under this authorization are for the purposes of allowing the Authorized Recipient to: (1) evaluate or cause evaluation to be prepared for a life expectancy based upon my health and medical status and condition in connection with all aspects of a viatical or life settlement transaction, and, (2) to verify or update said PHI on me through a process known as tracking or monitoring of my health, medical status, or life activities should the "Authorized Recipient" be retained to perform such.

D) Right To Revoke Authorization: I acknowledge and understand that I may revoke this authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser of my revocation of this authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser provided any revocation of this authorization shall not apply to the extent that an Authorized Discloser has taken action in reliance upon this authorization prior to receiving notice of my revocation.

I further understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure that may no longer be protected by the same rules that applied in the first instance. A photocopy of this authorization is as valid as an original.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

_____	_____	_____
(Signature of Individual)	(Print or Type Name of Individual)	(Date)

_____	_____
(Date of Birth)	(Social Security Number)