MAGNA LIFE SETTLEMENTS

805 Las Cimas Parkway
Suite 350
Austin, TX 78746

Phone: (512) 961-8265
Toll Free: (877) 315-0520
Fax: (512) 961-8264

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned Insured, authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:

1. Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, clinic, nurse, pharmacy, Pharmacy Benefit Manager, physician, physician practice group, laboratory, medical information service, and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to MAGNA LIFE SETTLEMENTS, INC., its affiliates and any of their directors, officers, employees, agents, designees, independent contractors, service providers or other representatives, a licensed life settlement provider, a licensed life settlement broker and Magna Life Settlements, Inc.'s, and its affiliates' respective successors and assigns (each, an "Authorized Recipient"), including without limitation, Vida Capital, Inc.; 21st Services, LLC; Examination Management Services, Inc.; Asset Servicing Group, LLC; Stratos Legal Services, LP and any insurance company that issued a policy under which my life is insured.

3. Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, as well as any other information derived from the foregoing, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including without limitation, information relating to any treatment or hospitalization, medical charts and records, clinical and doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, medical bills, pharmacy prescriptions, psychiatric conditions, AIDS/HIV, STD testing and treatment, drug or alcohol abuse/treatment, genetic testing, lab data and EKG's. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale or resale of any life insurance policy, or certificate of life insurance, under which my life is insured or any annuity under which my life is the measuring life and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance under which my life is insured.

4. Expiration of Authorization: This authorization shall remain valid until, and shall expire on, the date that is one (1) year following the date of my death.

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

6. Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization: I understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I 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, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

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

Signature of Insured (or POA)	Signature of Personal Representative of Insured
Print or Type Name of Insured (and POA if applicable)	Description of Personal Representative's Authority
Title (If corporate owned)	(Power of Attorney, Guardian ad I item or similar status
Date	Date