The Prudential Insurance Company of America
Prudential Claims
Tel: 800-524-0542 Fax: 844-552-9858

# Authorization to Release Information

**The Authorization is intended to comply with the HIPAA Privacy Rule**

For the purposes of evaluation of a claim for insurance benefits, I authorize all physicians, hospitals, clinics, medical providers, health plans, other health care providers, laboratories, insurance companies, pharmacies, pharmacy benefit managers, employers, investigative consumer reporting agencies and other agencies, including governmental organizations and the Social Security Administration, to provide to Prudential the Claimant's entire medical record (excluding psychotherapy notes), employment record, pharmacy record, insurance claim record, and insurance policy information. Upon the presentation of the original or photocopy of this signed authorization, I request the Social Security Administration to release to Prudential any and all information regarding earnings and any other information that may determine eligibility for benefits under the Social Security Act.

I authorize the entities listed above to permit Prudential or its authorized representative to obtain a copy of the entire medical record, including but not limited to, treatment for communicable diseases such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), drug and alcohol use and all other information relative to the physical health, mental health, dental care, or employment pertaining to Claimant.

For the purpose of processing and payment of claims in an efficient and prompt manner, I authorize Prudential to consolidate and disclose completed claim forms and documents to appropriate associates for each and every one of Prudential Financial, Inc.'s affiliates or business units for which a claim for payment or distribution is made.

First Name _____ Last Name _____

Claim number (if available) _____ Social Security number (last 4 digits) _____ Employee phone number _____ Date of birth (mm/dd/yyyy) / /

Control number _____ or Policy Number _____

This authorization will remain valid while the claim is pending, but not for more than two years except to the extent that state law provides a shorter duration. This authorization can be revoked by giving written notice to Prudential. Prudential may be unable to complete the claim process and may deny benefits if this form is unsigned or revoked. Prudential will not release this information to any other entity other than its reinsurers or service providers without written authorization, unless required or allowed by law or ordered by a court of law. A copy of this authorization form will be provided to you upon request. A photocopy of this authorization is as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time by sending a written request for revocation to Prudential at P.O. Box 70183, Philadelphia PA 19176. I understand that a revocation is not effective to the extent that any of my medical providers have relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under any insurance policy, or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Once disclosed to Prudential, this information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information. For purposes of this authorization, I hereby revoke any prior restriction on disclosure of medical records provided to any medical provider and authorize the release of the Claimant's entire medical record to Prudential, excluding psychotherapy notes.

X _____ / /
Signature Date (mm/dd/yyyy)

X _____
Witness

X _____
Relationship