Prudential

**Group Disability Insurance**

**The Prudential Insurance Company of America**
**Disability Management Services**
**P.O. Box 13480, Philadelphia, PA 19176**
**Tel: 800-842-1718 Fax: 877-889-4885**
**www.prudential.com/mybenefits**

# Group Disability Insurance
# Psychotherapy Notes Authorization

## 1 Employee Information

First Name | MI | Last Name

Claim Number | Social Security Number (Last four digits) | Employee Phone Number

Date of Birth (mm yyyy) | Control Number

## 2 Authorization for Release of Information to The Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose all psychotherapy notes concerning me to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose all of my psychotherapy notes without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy 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 13480, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of My Providers has 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release all of my psychotherapy notes, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

X _____ Date (mm dd yyyy)

Employee Signature (indicate how related if signed by other than claimant)