Prudential

Group Insurance

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/mybenefits

Authorization for Release of Health-Related Information for Own Serious Health Condition

1 Employee Information

This authorization is intended to comply with the HIPAA privacy rule.

First Name | MI | Last Name

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

Date of Birth (mm yyyy) | Control Number

I authorize my health care provider to give health information about me to The Prudential Insurance Company of America or it's agents, employees and representatives ("Prudential").

The health information to be given will be necessary and sufficient only to show that I have a "serious health condition" for purposes of determining eligibility for benefits under the Family and Medical Leave Act of 1993 and other related state leave laws ("FMLA").

I also authorize Prudential to contact any of my health care providers to clarify and authenticate any certification authorized by the FMLA laws.

This authorization will remain in effect for 12 months after the date of my signature below, except if any law has a shorter time frame. A copy of this authorization is as valid as the original.

I have the right to cancel this authorization by writing to:
The Prudential Insurance Company of America
P.O. Box 13480, Philadelphia, PA 19176

I understand that my cancellation is not effective if my health care provider, Prudential or my employer has relied on information given as a result of this authorization.

I know that any information given due to this authorization may be re-disclosed, to the extent allowable under law and no longer covered by certain legal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to determine my eligibility under the FMLA laws. A copy of this authorization is available upon request.

Date (mm dd yyyy)

X _____

Patient Signature (Explain relationship if other than patient)

* 6 9 1 6 3 A 0 1 *