MetLife®
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-800-230-9531

HIPAA: This Authorization has been carefully and specifi cally drafted to permit disclosure of health information consistent with the privacy rules adopted subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

_____ _____

Name of Employee (Please Print) **Social Security Number**

Claim Number: _____

Authorization to Disclose Information About Me

For purposes of administering my claim for disability benefi ts under my employer's short term and long term disability benefi t plans (which may include assisting me in returning to work), I permit the following disclosures of information:
I permit: any, physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, or government agencies administering state funded disability benefi ts or social security, to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of my employer's disability benefi t plans, and medical consultants and examiners that may be retained in connection with my disability claim any and all information concerning my current illness/injury, related medical care, and disability claim. I permit MetLife and my employer to disclose this information to each other for the above purposes.

This Form specifi cally grants my permission to disclose medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient and may no longer be covered by those rules.**

I understand that I may revoke this authorization at any time by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40511-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 18 months from the date I sign this form or the duration of my claim for benefi ts, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

_____ _____

Signature of Employee **Date**