



Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

Name of proposed insured/patient (please print)

____/____/_____
Date of birth

Social Security No.: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, to disclose my entire medical record and any other health information concerning me, without restriction, to The Prudential Insurance Company of America and its agents, employees and representatives ("Prudential"). This includes medical records and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers to restrict my protected health information and, for purposes of this authorization, I instruct My Providers to release and disclose my entire medical record without restriction to Prudential.

This information is to be disclosed under this Authorization so that Prudential may do the following, with respect to long term care insurance I have or am applying for: underwrite or make rating determinations, evaluate and determine my eligibility for long term care insurance, administer claims and other related policy provisions, obtain reinsurance, or conduct other legally permissible activities related to my application or coverage.

This authorization shall remain in force for 24 months following the date of my signature below, 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: The Prudential Insurance Company of America, Long Term Care Customer Service Center, P. O. Box 8519, Philadelphia, PA 19101, ATTN: Privacy Contact. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, Prudential may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that Prudential will provide me with a copy of this authorization.

Signature of Proposed Insured/Patient or Personal Representative

____/____/_____
Date

Description of Personal Representative's Authority or Relationship to Patient

PLEASE SIGN AND RETURN THIS COPY WITH YOUR APPLICATION

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