ASN

# AUTHORIZATION TO RELEASE INFORMATION

**MetLife Insurance Company of Connecticut**
P.O. Box 40007, Lynchburg, VA 24506-9939

**This is a HIPAA Compliant Authorization**

**CLAIM #** _____ **POLICY/CERTIFICATE#** _____

I authorize the use and disclosure of information about me as described below.

**Information to be Used or Disclosed:** This Authorization applies to medical and non-medical information/records about: my past, present, or future physical or mental health or condition; health care received; the past, present, or future payment for health care; and any related diagnosis, treatment, or prognosis. The Authorization also applies to my employment history such as dates of employment and dates worked; to all Social Security Administration records; contracts for admission to a long term care facility; and any other claim-related information. The authorized records include, but are not limited to, information about: drugs; alcoholism and mental illness; HIV status and related conditions; and may be in electronic or paper form.

**Who May Request or Use Information:**

[X] MetLife Insurance Company of Connecticut and its affiliates.

[X] Other: If you plan on having others (e.g. family members, friends) assist with the claims process, you may give them access to your health and financial information by specifying them here.
Financial Health Services, LLC: Kristin Jones, Kelly Keiserman, Kelly Fleckenstein, Jeannette Kudach, Janyne Wieder, Belle Swartz, Jalil Vazquez, Jackie Givnish

**Who is Authorized to Disclose Information:** All medical professionals, hospitals and care institutions, laboratories, long-term care facilities, insurers, medical service and prepaid health plans, group policyholders, employers, benefit plan administrators, care givers, care management agencies, care coordinators, care managers, pharmacies, Social Security Administration and any other Government Agency, insurance support organizations, consumer reporting agencies such as the MIB (Medical Information Bureau) or other individuals having information about me that is relevant to my claim for benefits.

**Purpose:** This information may be used or disclosed to evaluate a claim for insurance benefits.

**Statements of Understanding:** It is understood that: (1) this Authorization will be valid for the term of coverage of the policy under which a claim for insurance benefits has been submitted, unless limited by my residence state; (2) this Authorization may be revoked by writing to P.O. Box 40007, Lynchburg, VA 24506-9939; (3) If this Authorization is revoked, the revocation is not effective for any information that was previously used or disclosed in reliance on this Authorization; (4) Some of the health information obtained may be disclosed, pursuant to this authorization, to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws; (5) MetLife Insurance Company of Connecticut may not condition treatment, payment, enrollment or eligibility for benefits on the signature of this Authorization; (6) A copy of this Authorization will be considered as valid as the original.

Signature of Policy/Certificateholder — Date Signed

Name of Policy/Certificateholder

Personal Representative Signature (If applicable) — Date Signed

Personal Representative (Please Specify Relationship and if appropriate, attach Power of Attorney document)

(Company Copy)

*Effective 08/01/07*

MetLife Customer Service **Authorization for Disclosure of Information**
(PLEASE PRINT CLEARLY AND COMPLETE ALL **BOLDED** SECTIONS)

Name: _____
Group Name: _____
Group No.: _____

**Social Security Number:** _____

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health information (including demographic, billing, claim, and plan information) about my MetLife long-term care insurance to the person(s) listed below to allow that person(s) to assist me in matters related to my insurance coverage.

| Financial Health Services, LLC | Provider | 484-674-3760 |
|---|---|---|
| **Name** | **Relationship** | **Telephone Number** |
| **Name** | **Relationship** | **Telephone Number** |

I understand that this authorization will be valid until such time as I no longer have this long term care insurance, at which time it will expire, or until such time as this authorization is revoked by me, as permitted by law. I understand that I may revoke this authorization at any time by notifying MetLife in writing at the address in the enclosed letter, but if I do revoke this authorization, it will not have any effect on any information released before MetLife received the revocation.

I understand that once information is disclosed to the person(s) above, it may not be protected by HIPAA and other privacy rules. I further understand that the person listed above may re-disclose any information received.

I understand that this authorization is voluntary. I understand that the plan may not condition treatment, payment enrollment or eligibility for benefits on whether I sign this authorization.

_____ _____
**Signature of the Insured or his/her Personal Representative** **Date**

**If signed by Personal Representative of the Insured, please describe the authority under which the Personal Representative is authorized to act and enclose any related documentation (eg. copy of Power of Attorney).**

_____

_____

*This Authorization has been designed to comply with applicable requirements of Federal Privacy rules under the Health Information Portability and Accountability Act (HIPAA).

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FINANCIAL HEALTH SERVICES, LLC

# Financial Health Services, LLC

## Assignment of Benefits

This document is an assignment of benefits allowing Financial Health Services, LLC to receive payment as per your insurance coverage for home care services referred through _____ (Agency / Facility) for care beginning on _____ (Date).

This assignment should be signed and dated by you and returned to Financial Health Services, LLC as soon as possible.

**TO:** Claims Department at: _____

**FROM:** Policyholder's Name: _____

**RE:** Policy #: _____

Please accept this letter of Assignment of Benefits as an authorization to make payments directly to:

**Financial Health Services, LLC**
**325 Sentry Parkway**
**Building 5 East, Suite 160**
**Blue Bell, PA 19422**

Policyholder Signature: _____ Date: _____

**If signed by Personal Representative instead of Individual Named Above:**

_____
Name of Representative (Please Print)

_____
Relationship of Representative to Individual (e.g. Spouse, Power of Attorney, Guardian)

_____ _____
Signature of Representative Described Above Date