The Prudential Insurance Company of America
as administered by Concentrix Insurance Solutions
ATTN: Health Services Division
PO Box 19028
Greenville, SC 29602-9028

AUTHORIZATION
FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act (HIPAA), The Prudential Insurance Company of America as administered by Concentrix Insurance Administration Solutions Corporation (CIASC) may not use or disclose your health information except as provided in our Privacy Notice of Insurance Information Practices. Your signature on this form indicates that you are giving permission for certain use or disclosure of your health information.

I authorize the use or disclosure of my individually identifiable health information as indicated below by CIS to the following individual or entity (include name, address, and relationship):

_____

_____

The specific health information to be used or disclosed:

_____ Claim Payment Information
_____ Application/Enrollment Information
_____ Health Premium Payment Information
_____ Medical Records
_____ Other_____

Reason or purpose of providing the health information to the individual/entity named above:

_____

I understand this authorization will expire 24 months from the date the authorization is signed. I also understand that I may revoke this authorization at any time by providing CIASC with written notice of revocation. If I do revoke this authorization, it will not have any affect on any information released before CIASC's receipt of the revocation, including any action taken by the individual/entity that received the health information. Health information used or disclosed as instructed by this authorization may be further disclosed by the individual/entity receiving the health information and, therefore, no longer protected by the HIPAA privacy law.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization.

_____ _____
Signature of Individual who is the subject of the Health information Date

_____ _____
Print Name of Individual who is the subject of the Health information Policy Number

Submit the completed form to:

The Prudential Insurance Company of America
as administered by Concentrix Insurance Administration Solutions Corporation
ATTN: Compliance Support Services ✧ Post Office Box 19028, Greenville, SC 29602-9028

Note: If this authorization is signed by an authorized representative of the individual, provide a brief description of the representative's authority to act for the individual and attach supporting documentation (e.g. Power of Attorney, Estate Documentation) _____

Signature of Authorized Representative:_____