Prudential

**The Prudential Insurance Company of America**
**Disability Management Services**
**P.O. Box 13480, Philadelphia, PA 19176**
**Tel: 800-842-1718 Fax: 877-889-4885**
**www.prudential.com/mybenefits**

# AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

First Name | MI | Last Name | Claim Number

I authorize each of the Disclosers identified below to disclose any and all of my individually identifiable medical or health information and non-medical information as defined below ("Information") for the Authorized Uses described below, to the Users identified below.

**1. What Information is covered by this Authorization?**

This Authorization applies to all medical and non-medical information that is needed by the Users defined herein for one or more of the Authorized Uses. My Information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, records received from other health care providers, information regarding pre-existing health or medical conditions or illnesses, information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, mental illness, and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. Information also includes information about my occupation and employment activities, employee/employment records, earnings or finances, applications for insurance coverage, prior claim files and claim history.

**2. Who are the Disclosers who may disclose Information to Users under this Authorization?**

A. Any person or facility that attends, treats or examines me, including any health plan, physician, hospital, health care professional, clinic, laboratory, pharmacy, clearinghouse, data warehouse, or other organization that aggregates and maintains pharmacy data, MIB, Inc. (formerly known as Medical Information Bureau), medical facility or other health care provider that has provided services to or for me in the last ten years; any financial institution, accountant, tax preparer, insurance company, consumer reporting agency, insurance support organization, employers, government agencies including the Social Security Administration, or any other person or organization that possesses any of the Information described above, is authorized to make this Information available to Walgreens insurers and administrators, including Sedgwick Claims Management Services Inc, (Sedgwick); and/or any of their agents, representatives, disease management vendors and insurers, including, but not limited to, the Prudential Insurance Company of America.

B. I further understand that applicable law permits Sedgwick to re-disclose (without my further authorization) any and all of my individually identifiable medical or health Information, including information about any FMLA or other leave claim (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following, (a) Any person or facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors and service providers that may receive any such Information from my employer to the extent permitted by state or federal law; (d) service providers for my disability claim or workers' compensation claim or (e) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use my Information obtained pursuant to this authorization in any other claim matter that Sedgwick may administer or handle related to me or disclose it to other insurers or benefit administrators of Walgreens, including without limitation the Prudential Insurance Company of America for purposes of administering my disability benefits claim under the plan insured and administered by Prudential.

C. I specifically authorize physicians, nurses, hospitals and other health care providers who are Disclosers to communicate my Information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Users to initiate and conduct such communications whether or not I am present or have received notice thereof.

**3. Who are the Users who may get Information disclosed under this Authorization for Authorized Uses?**

Walgreens, its administrators including Sedgwick, disease management vendors and insurers of Walgreens including, but not limited to, the Prudential Insurance Company of America. For purposes of this Authorization, Authorized Uses means use for purposes of administering my disability claim(s) or request for reasonable accommodation.

**4. How long this Authorization is Valid?**

This Authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under applicable federal or state law.

Prudential

**The Prudential Insurance Company of America**
**Disability Management Services**
**P.O. Box 13480, Philadelphia, PA 19176**
**Tel: 800-842-1718 Fax: 877-889-4885**
**www.prudential.com/mybenefits**

# AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION

First Name | MI | Last Name | Claim Number

**5. Impact of Federal Law.**

I understand that the Information about me that I authorize to be used or disclosed may be re-disclosed as permitted by applicable law, and may no longer be protected by federal rules governing privacy and confidentiality of health information.

**6. Revocation of this Authorization.**

Unless otherwise provided by federal or state law, I understand that I may revoke this Authorization at any time by notifying, in writing, Sedgwick at, Sedgwick Claims Management Services, Inc., PO Box 14441, Lexington, KY 40512; Fax: 866-470-5767 of my revocation and that my revocation shall be effective upon Sedgwick' receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick or other Users before receipt of my revocation.

**7. Processing of Claims.**

I understand that this Authorization is generally necessary for the processing of my claim(s) or request for reasonable accommodation. Failure to sign this Authorization may impair or impede the processing of my claim(s) or request for reasonable accommodation.

**8. Refusal To Sign.**

I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

Printed Name of Patient or Patient's Representative

Representative's Authority or Relationship to Patient, if applicable

Employee ID Number

Patient's Date of Birth (MM YYYY)

Date Signed (MM DD YYYY)

**X** _____

Signature of Patient or Patient's Representative