



MetLife Disability  
 P.O. Box 14590  
 Lexington, Kentucky 40512  
 Fax: 1-800-230-9531

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

**NOTE TO ALL HEALTH CARE PROVIDERS:** 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.

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 this 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.**

Employee Name: \_\_\_\_\_ FMLA Claim #: \_\_\_\_\_

ID Number: \_\_\_\_\_ STD Claim #: \_\_\_\_\_

### **Authorization to Disclose Information About Me**

I understand that my employer has requested that Metropolitan Life Insurance Company ("MetLife") integrate the claim services for disability benefits and request for leave under the Family and Medical Leave Act (FMLA), state leave laws, and/or my company's leave of absence policy ("Leave Request"). For purposes of determining my eligibility for disability benefits and/or my Leave Request, the administration of my employer's disability benefit plan (which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any workers compensation, employee assistance or disease management program, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to MetLife, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and my claim for disability benefits and/or my Leave.
2. **I permit:** MetLife to disclose to my employer or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, workers compensation, employee assistance, or disease management programs, and to my employer regarding my Leave Request, any and all information about my health, medical care, employment, and claim for disability benefits or Leave Request. I also permit MetLife to contact any health care provider who has submitted a medical certification to MetLife in connection with my Leave Request in order to authenticate, clarify, or obtain any information missing from the certification.

**This Authorization to Disclose Information About Me** specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care, diagnosis 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 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 as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

**I understand** that I may revoke this authorization at any time by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40512-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits and/or my Leave Request, 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 \_\_\_\_\_

Date \_\_\_\_\_