Lincoln Financial Group®

Disability and Life Claims
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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

Person(s) or group(s) of persons authorized to disclose the information: Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies, governmental agency, MIB Inc., policy holder, reinsurance companies, policy or benefit plan administrator, and any insurance support organizations.

Person(s) or group(s) of persons authorized to collect or otherwise receive the information: The particular Company in the Lincoln Financial Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees, the Plan Sponsor (if self-insured Plan) and other organizations providing claims management services.

Description of the information that may be used or disclosed: This Authorization specifically includes the release of all psychotherapy notes relating to me, without restriction, including psychotherapy notes recorded in any medium documenting or analyzing the contents of conversations during private counseling sessions and/or group, joint or family counseling sessions.

The information will be used or disclosed only for the following purpose(s): To evaluate and administer my claim, and/or for insurance-related functions.

STATEMENTS OF UNDERSTANDING AND ACKNOWLEDGMENT:

I understand that information used or disclosed pursuant to this authorization could be redisclosed as necessary by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that I may revoke this authorization in writing at any time by sending a written notice to the Company in the Lincoln Financial Group of companies to which I have submitted a claim, except when action has been taken in reliance on this authorization, or when other law provides the Company with the right to contest a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.

I understand that authorizing the disclosure of this health information is voluntary and the health care services available to me are not dependent on if I sign this authorization. If I choose not to sign this authorization, insurance coverage or claim payments may be denied or delayed.

This authorization will be in force for 24 months from the date of signature, except if state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the Company's standard retention policy and applicable law. I understand that I may request a copy of this authorization.

Name of claimant (print) _____

Name of legal representative, if applicable (print) _____ Relationship _____

Signature of claimant or legal representative _____ Date: _____

Date of Birth: _____ Claim Number: _____

A copy of this authorization will be considered as valid as the original