AMERICAN HERITAGE LIFE INSURANCE COMPANY ("AHL")
1776 American Heritage Life Drive
Jacksonville, FL 32224

Telephone: (800) 521-3535
Customer Support Services Dept. Fax: (866) 428-2517
Claims Dept. Fax: (866) 424-8482

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE COMPLETE ALL SECTIONS ON BOTH PAGES

1. My Information

Name _____
Last First Middle

Home Address _____
Street City State/Zip Code

Phone _____ Date of Birth _____

Coverage Number(s) _____

2. My Health Information

The information that is subject to this Authorization consists of:

☐ Any information requested

☐ Health information about me created or received by AHL (e.g. claims information, etc.), except for the following: _____

☐ Other policy information (e.g. billing information, etc.). Please specify below:

_____

3. Recipient Information

I authorize AHL to disclose my health information described above to:

Name _____ Relationship _____

Address _____

*Must be 18 years or older

4. Purpose of Disclosure

My protected health information is being disclosed:

☐ At my request or at the request of my legal representative

☐ For the following purpose: _____

5. Term

This Authorization will remain in effect until:

☐ The termination of the above coverage(s).

☐ The _____day of_____, 20_____.

6. Authorization and Signature

I authorize disclosure in the manner described above, and understand that:

- This authorization is voluntary.
- The information I agree to share may be sensitive and may include information created by other entities, including health care providers. This information may include diagnosis and treatment information, which may address chronic diseases, behavioral health conditions, and communicable diseases. However, this authorization cannot be used to share psychiatric notes.
- AHL will not condition my enrollment or eligibility for insurance benefits on my provision of this Authorization.
- AHL does not guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

- I may revoke this Authorization at any time by sending written notice to the address below.
- This Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to AHL at the address listed above. The revocation will be effective upon AHL's receipt of my written notice.
- I may request a copy of this authorization form after I sign it.

Signature of Individual Date

Guardian or Legal Representative: Please complete the following and attach a copy of your legal authorization to represent the above individual.

Name Relationship

Street Address City State Zip Code

Signature of Guardian or Legal Representative Date

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS AND RETURN IT TO:

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, FL 32224
Claims Dept. Fax: (866) 424-8482