Member or Member's Dependent Authorization for Disclosure of Health Information - All States

(Applicable to Group Dental and Vision Customers)

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

1. I authorize Principal Life Insurance Company and its business associates to disclose information as described below.

   a) Please disclose information to:

   Name: _____

   Address: _____

   _____

   b) Describe the health information to be disclosed (check as applicable):

   ☐ Please disclose any and all health information requested by the person or entity described above.

   ☐ Please describe the health information to be disclosed:

   Description: _____

   _____

   c) Reason for the disclosure (optional):

   _____

2. I understand my health information may be used or disclosed as set forth by this authorization. This includes protected health information created or received by Principal Life. Protected health information may include but is not limited to:

   - Benefit information
   - Claim information
   - Treatment records/office notes
   - Diagnosis
   - Medications
   - Test results
   - Consultation reports
   - Hospital records

3. If you are the representative of the person whose information is to be shared, describe the scope of your authority to act on the person's behalf; for example, power of attorney, guardian, conservator:

   _____

4. I hereby authorize the person or entity names above to act as my representative on my behalf with respect to a benefit claim, or appeal of an adverse benefit determination, pursuant to DOL regulation 29 CGS 2560.503-1, or if applicable, a request for documents pursuant to ERISA section 104 (b) (4).

5. I understand that I may revoke this authorization at any time. The request for revocation must be in writing and sent to: Compliance Privacy Consultant, Specialty Benefits Division Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. I understand that a revocation is not effective if Principal Life has relied on the information disclosed to it. Such revocation shall not apply to any use or disclosure of my information specifically permitted by applicable regulations, and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures permitted without my authorization.

6. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure.

7. I understand that this authorization form will be valid for 12 months following the date of my signature below.

8. I understand that I am not required to sign this authorization form and that Principal Life will not condition the provision of a claim for dental and/or vision on the signing of this authorization, but I must do so, in order for the authorization to be valid.

By my signature, I acknowledge that any prior agreements I have made to restrict my health information do not apply to the information released under this authorization.

Name of person whose information is to be shared (please type) **Date of birth** **I.D./Policy number**

Address of person whose information is being shared **Phone number**

Employer name **Account number**

Employer address

Name of personal or legal representative (if applicable)

Relationship of personal or legal representative to person whose information is to be shared
If signing on behalf of another, please attach the proper documentation that attests to your ability to sign (Court stamped Letters of Appointment as Executor of Estate, proof of custody, power of attorney, etc.)

Signature of person whose information is to be shared (or person's representative) **Date**

NOTE: ANY ALTERATIONS TO THE LANGUAGE IN THIS DOCUMENT MAY RESULT IN THE DOCUMENT BEING RENDERED INVALID.

Print