MetLife Disability
PO Box 14681
Lexington, KY 40512
Fax: 1-877-840-9166

Metropolitan Life Insurance Company

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.

AUTHORIZATION TO RELEASE PSYCHOTHERAPY TREATMENT RECORDS AND NOTES.

For disability claim purposes regarding the Claimant named below, I authorize:

- Any medical practitioner or facility or related entity, psychiatrist, psychologist or social worker or other mental health professional, health service plan, or insurer, to give Metropolitan Life Insurance Company ("MetLife") and the Claimant's employer's disability benefit plan (the "Plan") in the format requested, including by telephone, fax, or mail, all psychotherapy treatment records and notes about the Claimant.

I understand that:

- All or part of the information, records and data that is received pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate, independent contractor, or other entity who performs a business service in the administration or insuring of the Claimant's employer's disability benefit plan (the "Plan") for MetLife or the Plan, or disclosed or used as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or the Plan, may no longer be covered by those laws or regulations. Your health care provider may not condition your treatment on whether you sign this authorization.
- Unless revoked, this authorization will be valid for 24 months from the date it is signed or the duration of the claim for benefits, whichever period is shorter. I may revoke this authorization at any time by writing to MetLife Disability at P.O. Box 14681, Lexington, KY 40512, except to the extent that action has been taken in reliance on it.
- **A photocopy of this form is as valid as the original form and I have a right to receive a copy upon request.**

Print Name of Claimant: ______________________________

Signature (Claimant **or** Claimant's Legal Representative)

Claimant's Signature: ______________________________ **Date:** ____________________

Signature of Claimant's Legal Representative: ______________________________ **Date:** ____________________

Print Name and representative capacity of Legal Representative: ______________________________