Re: Voluntary Release of Information

Dear Dental Plan and/or Vision Plan Participant:

At MetLife, we are dedicated to protecting your right to privacy. That is why if you would like to authorize someone, such as a spouse, relative, or friend, to help you with matters concerning your dental and/or vision benefits, we ask you to review, complete and sign the enclosed authorization and return it to us by mail, fax or e-mail to:

MetLife
PO Box 14587
Lexington, KY 40512

Fax: **1-859-389-6505**

E-mail: **dental@metnotices.com**

Note that the completion and return of this authorization is completely voluntary. This will allow us to release information about your dental and/or vision benefits, including health information, to the person(s) specified. Please remember that this concerns your personal records, and that the form can only be signed by you or by your legally authorized representative (such as a power of attorney, guardian, or conservator).

If you have any questions, please call us toll free at **1-800-942-0854 Monday through Thursday, 7:00 AM to 7:00 PM (ET); and Friday, 7:00 AM to 5:00 PM (ET).** A MetLife customer service representative will be happy to assist you. Thank you for choosing MetLife.

Sincerely,

Metropolitan Life Insurance Company Dental and Vision Program Management

HIPAA* AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please Print Clearly and Complete in its Entirety.

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose Personal Health Information about me relating to my coverage under the:

☐ **DENTAL PLAN** ☐ **VISION PLAN**

DENTAL AND/OR VISION

Administered by: MetLife
PO Box 14587
Lexington, KY 40512
Fax: 1-859-389-6505
E-mail: dental@metnotices.com

Disclosure is initiated by me and authorized for the following purpose/reason: (You must check one.)

- ❑ To assist me in my inquiry about claims or other activities related to my dental and/or vision benefits.
- ❑ I elect not to provide a statement of purpose/reason. Please make the disclosure at my request.
- ❑ Other purpose/reason – describe in detail.

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Personal Health Information to be disclosed: (You must complete one of the following.)

❑ I authorize MetLife to release my personal health information relating to my dental and/or vision benefits (including billing, claim and plan information) for (check one) ___ all years, or ___ the current year, or ___ the following years: _____________.

OR:

❑ The personal health information described below. (Please provide a detailed description including dates if applicable. MetLife will not make a disclosure unless the information requested to be disclosed is specifically identified.)

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COVERED PERSON - NAME (print)	First	Middle	Last	Employee SSN or ID #
Address	City	State	Zip Code	Group # (if applicable)

Name and address of person or entity authorized to receive the specified Personal Health Information:

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By signing below, I acknowledge and understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by writing to MetLife at the address above. If I do not revoke this authorization, it will be valid until such time as I am no longer covered under this dental and/or vision benefit plan. My revocation will not apply to any action taken before MetLife receives it.
- The plan(s) may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- Personal Health Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.

Signature of Covered Person or
Personal Representative of the Covered Person: ______________________________ Date:__________

If signed by Personal Representative of the Covered Person, please describe the authority under which the Personal Representative is authorized to act:

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* This Authorization has been designed to comply with applicable requirements of federal privacy rules under the Health Insurance Portability and Accountability Act (HIPAA)