AUTHORIZATION TO RELEASE/UPDATE INFORMATION – AFLAC DENTAL & VISION

MAIL TO: American Family Life Assurance Company of Columbus
4211 W. Boy Scout Blvd Ste 295
Tampa, FL 33607

CALL: 1.855.819.1873 (toll-free)

Person's Whose Information Is to be Disclosed:		
Name:	**SSN**(optional):	**Date of Birth:**
ID Number:		
Address:		

Information to be disclosed:

- ☐ **All records**
- ☐ **Records from the following dates:** _____
- ☐ **Records relating to the following treatment or condition:** _____
- ☐ **Other (Please describe):** _____

Purpose of release of information:

- ☐ **At my request**
- ☐ **Medical Care**
- ☐ **Litigation/Legal**
- ☐ **Other (Please describe):** _____

Aflac May Release Information to The Following Person/Entity:
Name:
Address:
Relationship to the Member: ☐ Family Member ☐ Guardian ☐ Provider ☐ Other (Explain): _____
☐ If checked, I further appoint said individual as my authorized representative to **change** or **update** my coverage, billing or demographic information.
APPOINTMENT OF AN AUTHORIZED REPRESENTATIVE FOR THESE PURPOSES IS ONLY VALID IF THIS FORM IS BEING SIGNED BY THE PRIMARY MEMBER OR THEIR LEGAL REPRESENTATIVE.

I. Authorization:

For medical treatment or consultation, billing or claims payment, or other purposes as I may direct, I authorize Aflac Dental & Vision (defined as American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York or Tier One Insurance Company[1]) ("Aflac") to release Information (as defined below) to any parties listed above. "Information" includes protected health information and nonmedical financial information in Aflac's possession relating to my dental and/or vision coverage, including, for example, enrollment/eligibility information, claim information (e.g., medical records, payment, status) and insurance Information.

II. Rights and Expiration:

I understand that I may revoke this authorization at any time, except in the event Aflac has already shared my Information by the time my authorization is revoked. To revoke this authorization, I must provide a written and signed revocation to Aflac at the address above. Unless otherwise revoked, this authorization shall remain in effect for two years from the date signed. I agree that a copy of this authorization is as valid as the original. I agree to make a copy of this signed authorization for my records; however, I may also request a copy of this signed authorization directly from Aflac.

III. Notice:

I understand that Aflac is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if a person or entity that receives my Information is not covered by federal privacy regulations, my Information may be re-disclosed by such person or entity and will then no longer be protected.

- **If records are on an adult dependent (e.g. spouse, child over 18), the dependent must sign this form.**
- **If records are on a minor child, the natural parent or legal guardian must sign on their behalf.**

_____ _____
Member's Signature Date Signed

_____ _____ _____ _____
Legal Representative's Signature Legal Representative's Printed Name Legal Relationship Date Signed

If this document is being signed by a Legal Representative *(e.g. Legal Guardian, Estate Administrator, Power of Attorney)*, please provide us with the court appointed documents granting this authority.

[1]*Tier One Insurance Company does business as Tier One Life Insurance Company in California (Tier One NAIC 92908)*