Print...

New York Life Insurance Company
Individual Disability Insurance
1500 Main Street, Suite 1400, P.O. Box 15189
Springfield, MA 01115-5189

Authorization to Release Personal Information - Individual Disability Insurance

I give my permission to release information to New York Life:

Insured's Name		
FIRST	M.I.	LAST

I authorize medical information concerning the above-named Insured to be released to New York Life**, its agents, its employees, its affiliates, and acting on its behalf: attorneys, reinsurers,claims consultants, financial consultants, medical professionals, insurance support groups, and third-party administrators. This authorization applies to any physician, health-care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, hospice, nursing home, assisted living facility, home health care agency, other medical facility, adult day care provider, adult foster care provider, other health care provider, insurance company, group policyholder, or benefit plan administrator that has provided payment, treatment, or services to the above named Insured and permits them to disclose medical records covering such payment, treatment, or services to the above named Insured to New York Life, for the purpose of evaluating this claim for benefits. This includes, but is not limited to, all data reports and records that contain history, findings, diagnosis, prognosis, and treatment(s) about the named Insured's physical and mental health, medical examinations or tests, prescriptions, medical diagnosis and prognosis, HIV infection, any disorder of the immune system including **Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), mental or emotional illness, the use of drugs, the use of alcohol,** and the use of tobacco, but excludes psychotherapy notes. This also includes any portion of the named Insured's medical records during this period I have previously withheld from release, which I hereby terminate for the purposes of this authorization.

I also authorize the release of non-medical information concerning the above-named Insured, including other insurance coverage, **employment history, earnings or finances, driving records,** or information otherwise needed to determine policy claim benefits due. This information can be released by any consumer reporting agency, insurance support organizations, the Social Security Administration, the Internal Revenue Service, the Veteran's Administration, offices of the government, employers, insurance companies, group policyholders, benefit plan administrators, or any other organization or person having any knowledge of the above named Insured.

I agree the information obtained by this authorization may be used by New York Life to determine eligibility for claimed benefits with respect to the above-named Insured. I further agree that for the purpose of evaluating this claim for benefits, any information obtained by this authorization may be disclosed by New York Life to its agents, its employees, its affiliates and acting on its behalf: attorneys, reinsurers, claims consultants, financial consultants, medical professionals, insurance support groups, and third-party administrators.

I know I have the right to revoke this authorization at any time by notifying New York Life in writing, at the address shown on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed, collected information, or taken other action in reliance on it. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

I understand that if I revoke, or fail to sign this authorization, or alter its content in any way, New York Life will not be able to process my claim for benefits.

I know that I can request a copy of this authorization and a copy of this authorization shall act as the original. This authorization is valid for two years from the date shown below or when the claim terminates, whichever is shorter, unless revoked by me in writing.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

Signature of Insured or Insured's Authorized Representative	Relationship to Insured	Date

Authorized Representative must provide proper documentation, i.e. Power of Attorney or Guardianship papers.

* If the subject of information is incapacitated, the authorization form must be signed by an authorized representative such as a conservator, guardian, or person with power of attorney.

** All references to "New York LIfe" mean New York Life Insurance Company and its subsidiaries: New York Life Insurance and Annuity Corporation (NYLIAC) and NYLife Insurance Company of Arizona (NYLAZ). NYLAZ is not authorized in New York or Maine, and does not conduct insurance business in New York or Maine.

Send us your completed form.

Mail: **New York Life, Individual Disability Insurance, 1500 Main Street, Suite 1400, P.O. Box 15189, Springfield, MA 01115-5189**

Fax: **1-(833) 963-3462** Email: **IDIClaims@IDI.newyorklife.com** Questions? Call us at (844)-420-1391