



AMERICAN HERITAGE LIFE INSURANCE COMPANY ("AHL")
1776 American Heritage Life Drive
Jacksonville, FL 32224
Telephone: (800) 521-3535
Facsimile: (866) 428-2517

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name Last First Middle
Home Address Street City State/Zip Code
Home Telephone Date of Birth
Policy Number(s)
MY HEALTH INFORMATION: The health information that is subject to this Authorization consists of:
[ ] All Health information about me created or received by AHL, except for the following:
[ ] Other (for example: policy benefit amounts, all claims information, etc.). Please specify below:
AUTHORIZED DISCLOSURE
I authorize AHL to disclose my health information described above to the recipient named below:
Name ("Recipient")
Address
TERM: This Authorization will remain in effect until:
[ ] I revoke it in writing.
[ ] the \_\_\_ day of \_\_\_, 20\_\_.

- I authorize disclosure in the manner described above, and understand that:
• AHL will not condition my enrollment or eligibility for insurance benefits on my provision of this Authorization.
• AHL does not guarantee that Recipient will not redisclose my health information to a third party.
• I may revoke this Authorization in writing at any time.
• This Authorization will remain in effect until the Term of the Authorization expires or I provide a written notice of revocation to AHL at the address listed above.

Signature of Individual

Date

Signature of Witness