



Mailing Address:
P.O. Box 39710
Colorado Springs, CO
80949-3910

Principal Life
Insurance Company

Member or Member's Dependent
Authorization for Disclosure of
Personal Health Information - All States
*(Applicable to Group Medical, Dental, and
Vision Customers)*

**This authorization complies with the HIPAA Privacy Rule and permits health care providers
and other covered entities to disclose personal health information**

1. I initiate this authorization for disclosure of my personal health information (defined in #2). I authorize Principal Life Insurance Company, its agents, and business associates to disclose my personal health information as described below. *Statement required by §164.508(c)(1)(ii).*

a) Please disclose my personal health information to (check as applicable):

My employer/plan sponsor (Please include name and address of employer/plan sponsor): *Statement required by §164.508(c)(1)(iii).*

Employer: _____

Attn: _____

Address: _____

Another person or entity (Please include name and address of person or entity to whom the information is to be released): *Statement required by §164.508(c)(1)(iii).*

Name: _____

Address: _____

b) Describe the personal health information to be disclosed (check as applicable): *Statement required by §164.508(c)(1)(i).*

Please disclose any and all personal health information requested by the person or entity described above.

Please describe the personal health information to be disclosed:

Description: _____

c) Reason for the disclosure (optional): *Statement required by §164.508(c)(1)(iv).*

By my signature, I acknowledge that any prior agreements I have made to restrict my personal health information do not apply to the information released under this authorization.

2. I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by Principal Life. Protected health information also includes but is not limited to: *Statement required by §164.508(c)(1)(i).*

- Hospital records
- Treatment records/office notes
- Alcohol or drug abuse treatment
- Consultation reports
- Workers' compensation information
- Diagnosis
- Prescriptions
- Test results
- Vocational testing/counseling information
- Benefit information

3. If you are the representative of the member or the member's dependent (including a member acting as a representative on a dependent's behalf) describe the scope of your authority to act on the member's or dependent's behalf; for example, power of attorney, guardian, conservator: *Statement required by §164.508(c)(1)(vi).*
4. I understand that any information disclosed under this authorization may no longer be covered by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*
5. I understand that I may revoke this authorization at any time. The request for revocation must be in writing and sent to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. To request a revocation form, contact the Health Information Protection Analyst. I understand that a revocation is not effective if Principal Life has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without my authorization.
6. This authorization will be valid for 24 months following the date of my signature below. *Statement required by §164.508(c)(1)(v).*
7. I understand that I am not required to sign this authorization form and that Principal Life will not condition the provision of payment of a claim for medical, dental, and/or vision coverage on the signing of this authorization. *Statement required by §164.508(c)(2)(ii).* No alteration of this form will be accepted.

I initiate this authorization for disclosure of personal health information. I have read and I understand this authorization. Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* A photocopy of this authorization shall be considered as effective and valid as the original.

Member/Dependent name (please print) **Date of Birth** **I.D. Number**

Member/Dependent address **Phone Number**

Employer Name **Account Number**

Employer Address

Name of personal or legal representative (if applicable)

Relationship of personal or legal representative to Member or Dependent.
 If signing on behalf of another, please attach the proper documentation that attests to your ability to sign (Death Certificate, court-stamped Letters of Appointment of the Executor of Estate, proof of custody, power of attorney, etc. *Statement required by §164.508(c)(1)(vi).*

Signature of Member/Dependent (or Member's or Dependent's representative) **Date**
Required by §164.508(c)(1)(vi).