AUTHORIZATION TO RELEASE INFORMATION – LEGAL PURPOSES

MAIL TO: American Family Life Assurance Company of Columbus
1932 Wynnton Road
Columbus, Georgia 31999-000

CALL: 1.800.992.3522 (toll-free)
FAX TO: 1.706.596.3270 (Legal Dept.)
EMAILTO: legaldocumentrequest@aflac.com

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address:		
Name of Person Whose Records Are Being Requested (if different from above):		**Date of Birth:**
Relationship to Primary Policyholder: ☐Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		
Aflac May Release Information To The Following Person/Entity:		
Name: RECORDS DEPOSITION SERVICE		
Relationship to Person Whose Records Are Being Requested: ☐ Attorney ☑ Other (explain): THIRD PARTY COPY SERVICE		
Aflac May Release Information By: (check all that apply and please print clearly)		
☐ regular mail/carrier	**Address:**	
☑ email **(see below)**	**Email Address:** REQUESTS@RECDEP.COM	
____ **Initial** If email is selected; I understand that there may be some level of risk that the Information in the email could be read by a third party. I do hereby agree to indemnify and hold harmless Aflac, its employees, and agents from any unauthorized access of protected health information while in transmission and after delivery to the indicated email address.		
☑ facsimile (fax)	**Fax Number:** 248-357-3337	

Authorization and Indemnity:

I, the undersigned, hereby authorize Aflac or any person or entity acting on its part to release any information (defined below) concerning me or any of my policies to the person or entity identified above. "Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting or a claim for benefits), and non-medical financial information (including, for example, policy premium and status information).

Purpose, Rights, and Expiration:

- I understand that this Information will be used for purpose of legal representation and/or litigation.
- This authorization shall remain in effect for one (1) year from the date hereof, unless revoked by me. I understand that I may revoke this authorization at any time, except to the extent that Aflac has taken action in reliance on this authorization. To revoke this authorization, I must provide a written and signed revocation to Aflac at the address above.
- 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 authorization directly from Aflac.

Notice:

I understand that Aflac is not conditioning payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and if the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The undersigned hereby waives any restrictions on disclosure imposed by law on Aflac and releases Aflac, its officers, directors, employees and agents from any liability associated with the release of any information pursuant to this authorization.

- **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.**

_____ _____
Signature of Person Whose Records Are Being Requested — Date Signed

_____ _____ _____ _____
Legal Representative's Printed Name — Legal Representative's Signature — 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.