Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765 Fax (877) 573-6177
www.LincolnFinancial.com

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION

1. **I (the undersigned) authorize** The Lincoln National Life Insurance Company ("Company") to release information regarding:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____ Certificate Number/Social Security Number: _____

2. Information to be released: _____

   _____

   _____

   _____

3. Information to be released to: _____
   (Name of individual or company authorized to receive information)

   Best Day to call _____

   □ Telephone _____ - _____ - _____ Best time to call _____ am/pm
   Include Area Code and Phone number

   □ Address

   _____
   (Street/PO Box) (City) (State) (Zip)

4. I understand the information obtained by use of this Authorization will be used by _____ for the purpose of _____.

   It will be subject to the following limitations (if applicable): _____

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law.

6. This Authorization will be valid until the information requested above has been released. Once the Company has released the information as requested, no further disclosure may be made by the Company without another Authorization to do so. In no event will this authorization be valid for longer than 24 months.

7. I understand that I may revoke this Authorization in writing at any time. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ **DATE:** _____
Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____
(Street/PO Box) (City) (State) (Zip Code)

TELEPHONE: _____ - _____ - _____
Include Area Code and Phone number