Request and Authorization for Disclosure of Health Information

PLEASE PRINT or TYPE

EFFECTIVE AS OF _____

This is an authorization requesting _____ [Name of Health Plan-organization that will release your information] to release individual health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or by state law protecting the privacy of health information. I hereby authorize the use and disclosure of the individually identifiable health information as described below.

(1) The request for release of information is being made **for** the dental plan member identified below.

_____ _____ ___/___/_____
Identification Number Member's Name Date of Birth

_____ (___)____-_____
Mailing Address Telephone Number

(2) Specific description of information that may be used/disclosed:

☐ Claims Information ☐ Payment Information

☐ Other Information (must provide specific description): _____

_____

(3) The information will be used/disclosed for the following purpose(s):

☐ Obtaining Claims Information or Payment Information for the Resolution of Claim Processing or Payment Issues

☐ Other: _____

(4) Persons/organizations **authorized to receive** the information:

☐ Family Members (must list name and relationship): _____

_____ _____ _____

☐ All Group Health Plan Representatives at member's place of employment (provide name of member's employer): _____

☐ Other (must list names and relationship to member): _____

_____

(5) I understand that I may revoke this authorization at any time by sending a written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action your dental plan or it's subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, my dental plan may not use or disclose my health information for any reason except those described in Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date.

This authorization expires on ____/____/_____. [Insert applicable date. If no expiration date is stated, this authorization will be deemed to expire one year from the date of execution.]

I understand that authorizing the disclosure of this health information is voluntary, and is not a condition of enrollment in this health plan's eligibility for benefits, or payment of claims.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I release my dental plan, its affiliated companies, employees, officers and business associates from legal liability for any recipient's use or disclosure of information released by my dental plan in reliance on this authorization.

_____ _____

Signed (member or personal representative) Date

_____

Printed name of signature above (member's personal representative)

_____

Description of the representative's authority to act for the member

You are entitled to a copy of this authorization after you sign it. Any revocation or change to this authorization, or any questions regarding its legal effect, should be addressed to:

Dental Customer Service
P.O. Box 69420
Harrisburg, PA 17106-9420

If you have any questions, please call Dental Customer Service at the telephone number located on the back of your identification card. You may fax this form to 1-866-335-3969 or return the form to the address listed above.