LIBERTY DENTAL PLAN

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SECTION 1: MEMBER INFORMATION

Member last name	*Member first name*	*Member date of birth* _____ / _____ / _____	
Member street address	*City*	*State*	*ZIP Code*
Member phone number	*Member identification number (see identification card)*		

SECTION 2: INDIVIDUAL OR COMPANY AUTHORIZED TO RECEIVE MEMBER INFORMATION

I am authorizing the individual or company named below to receive my information:

Individual name (first and last name)	*Company name (if applicable)*		
Street address	*City*	*State*	*ZIP Code*
Relationship to the Member (e.g., parent, spouse, domestic partner, adult child, insurance broker or agent, attorney, etc.)			
Purpose of the disclosure			

SECTION 3: MEMBER INFORMATION TO BE DISCLOSED

I am authorizing the individual or company named in Section 2 to receive the following types of my information:

☐ **All of my information** (including, but not limited to, dental records, claims and information regarding eligibility, financial and billing, benefits, provider/dental office assignment, pre-treatment authorizations and specialty referrals, etc.

☐ **Only the following types of my information** (*check all that apply*)

- ☐ Eligibility information
- ☐ Benefits
- ☐ Claims
- ☐ Dental records (including x-rays)
- ☐ Provider/dental office assignment information
- ☐ Pre-treatment authorizations and specialty referrals
- ☐ Financial and billing information
- ☐ Other (*please specify*): _____

SECTION 4: EXPIRATION OF AUTHORIZATION

Unless I revoke my authorization in accordance with the procedures in Section 5, my authorization will expire on:

☐ **Two** (2) years from the date of my signature in Section 5 **OR** ☐ the **earlier** date of: _____ / _____ / _____

SECTION 5: ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I hereby authorize LIBERTY Dental Plan and/or its affiliates or designees to disclose the types of information identified in Section 3 to the individual or company identified in Section 2. In addition, by signing below, I acknowledge and agree to the following:

I have fully reviewed this Member Authorization Form (the "Form"), and I understand the contents of this Form. My authorization is being given voluntarily, and I understand that I can revoke my authorization at any time by providing written notice of my revocation to LIBERTY Dental Plan at (888) 703-6999 but that revocation of my authorization will not affect any action that has already been taken or any of my information that was released prior to LIBERTY Dental Plan's receipt of written revocation. I further understand that information disclosed to the individual or company identified in Section 2 could be further disclosed by that individual or company and that the Health Insurance Portability and Accountability Act and/or privacy laws may no longer protect such information.

*Member signature: (**must** be age **18** or over)*	*Print Member name:*	*Date:* _____ / _____ / _____
*Parent signature: (IF member is a minor = age **17** or under)*	*Print Parent name:*	*Date:* _____ / _____ / _____

PLEASE SEND COMPLETED FORM TO:	
340 Commerce, Suite 100, Irvine, CA 92602	Or FAX to: 949-270-0101