

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SECTION 1: MEMBER INFORMATION

<i>Member last name</i>	<i>Member first name</i>	<i>Member date of birth</i> ____ / ____ / ____	
<i>Member street address</i>	<i>City</i>	<i>State</i>	<i>ZIP Code</i>
<i>Member phone number</i>	<i>Member identification number (see identification card)</i>		

SECTION 2: INDIVIDUAL OR COMPANY AUTHORIZED TO RECEIVE MEMBER INFORMATION

I am authorizing the individual or company named below to receive my information:			
<i>Individual name (first and last name)</i>	<i>Company name (if applicable)</i>		
<i>Street address</i>	<i>City</i>	<i>State</i>	<i>ZIP Code</i>
<i>Relationship to the Member (e.g., parent, spouse, domestic partner, adult child, insurance broker or agent, attorney, etc.)</i>			
<i>Purpose of the disclosure</i>			

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:	
<input type="checkbox"/> 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.	<input type="checkbox"/> Only the following types of my information (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Eligibility information <input type="checkbox"/> Benefits <input type="checkbox"/> Claims <input type="checkbox"/> Dental records (including x-rays) <input type="checkbox"/> Provider/dental office assignment information <input type="checkbox"/> Pre-treatment authorizations and specialty referrals <input type="checkbox"/> Financial and billing information <input type="checkbox"/> 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:	
<input type="checkbox"/> Two (2) years from the date of my signature in Section 5	OR <input type="checkbox"/> 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.

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

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