Authorization to Disclose Protected Health Information (PHI)

LIBERTY DENTAL PLAN

SECTION 1: Member Information

Member's Last Name:	Member's First Name:		Member's Date of Birth:
Member's Address:	City:	State:	Zip Code:
Member's Phone Number:	Member's ID Number (see LIBERTY ID card):		

SECTION 2: Person or Company Allowed to receive PHI

I am giving the person or company named below permission to receive my personal information:			
Person's Name (first and last name):	Company Name (if applicable):		
Address:	City:	State:	Zip Code:
Relationship to the Member (Such as: family, broker, provider, lawyer)			
Reason for sharing:			

SECTION 3: Member Information to be Disclosed

I allow the person or company named above to have access to:

☐ **All of my information** (such as dental records, claims and information regarding eligibility, financial and billing, benefits, my dentist/dental office, pre-treatment authorizations and referrals, etc.)

Or, only the following types of information (check all that apply):

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

SECTION 4: End of Authorization Date

Unless I ask to cancel my authorization, this authorization will end (select one) – *if blank authorization will expire in two (2) years*

☐ Two (2) years from the date signed

☐ On: _____

SECTION 5: Acknowledgments and Signature

By signing below, I give LIBERTY Dental Plan and/or its affiliates or designees permission to disclose the types of information identified in Section 3 to the person or company identified in Section 2 above.

Also, by signing below, I understand and agree to the following:

- I have fully looked over this Member Authorization Form (the "Form"). I understand what this Form says. I agree to these terms on my own free will.
- ***This authorization is solely for the purpose of creating PHI for disclosure to the person or company named in Section 2. By refusing to sign this Form, the person or company named in Section 2 will not be able to receive my PHI.***
- I know that I can cancel my authorization at any time by sending a written request to LIBERTY Dental Plan at the contact details below. Canceling my authorization will not change any action that has already been done or any of my information that was given prior to LIBERTY Dental Plan's getting my written notice.
- I also understand that information given to the person or company named in Section 2 could be passed on by that person or company and that the Health Insurance Portability and Accountability Act (HIPAA) and/or other privacy laws may no longer protect this information.
- I acknowledge that I may access LIBERTY Dental Plan's Notice of Privacy Practices online at www.libertydentalplan.com/About-LIBERTY/Compliance/HIPAA-Privacy-Notice.aspx.
- I understand that authorizing the disclosure of my information is voluntary, LIBERTY Dental Plan and/or its affiliates or designees will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the Form.
- I understand that I have the right to receive a signed copy of this Form upon request.

Member's Signature (must be 18 or over):	Print Member's Name:	Date:
Parent or Guardian's Signature (if Member is age 17 or under):	Print Parent or Guardian's Name:	Date:

This Form must be signed by the Member – OR – a person with the legal right to act for the Member (Guardian, Attorney, Power of Attorney, etc.,).

If the Form is submitted by someone other than the Member, please provide a description of and support for authorization to act on behalf of the Member.)

Please send the Completed Form to:	
340 Commerce, Suite 100, Irvine, CA 92602	Or by Fax: (888) 704-9930
Or Email to Eligibility@libertydentalplan.com	