Authorization to Disclose Protected Health Information (PHI)

Section 1: Enrollee Information

Last Name:	First Name:		Date of Birth:
Address:	City:	State:	Zip Code:
Phone Number:	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 recieve my personal information:

Person's Name:		Company Name *(if applicable)*:	
Address:	City:	State:	Zip Code
Relationship to the Enrollee (Such as family, broker, provider, lawyer):			
Reason for sharing:			

Section 3: Enrollee 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.)

Only the following types of information *(Check all that apply)*

- ☐ **Eligibility Information**
- ☐ **Financial and Billing Information**
- ☐ **Benefits**
- ☐ **Dental Records** *(Includes X-rays)*
- ☐ **Claims and Referrals**
- ☐ **Other** *(Please Specify)*
- ☐ **Provider/Dental Office Assignment Information**
- ☐ **Pre-Treatment Authorizations**

Section 4: End of Authorization Date

Unless I ask to cancel my authorization, this authorization will end *(Select one)*:

- ☐ Two (2) years from 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.

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 understand that authorizing the disclosure of my information is voluntary, but that the following conditions may apply. [Provider to check appropriate category]

- ◯ 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.
- ◯ This authorization is for the provision of research related treatment. By refusing to sign this Form, I will not be eligible for treatment as part of this research study.
- ◯ This authorization is for eligibility, enrollment, underwriting, or risk rating determinations for a health plan. By refusing to sign this Form, I may not be able to enroll or be eligible for benefits in the health plan.
- ◯ 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 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 understand that I have the right to receive a signed copy of this Form upon request.

Enrollee's Signature: *(Must be over 18)*	Print Enrollee's Name:	Date:
Parent or Guardian's Signature: *(If enrollee is age 18 or under)*	Print Parent or Guardian's Name:	Date:

Please send the completed form to:	
Mail: LIBERTY Privacy Officer, 340 Commerce, Suite 100, Irvine, CA 92602	Fax: (833) 250-1814
Email: privacy@libertydentalplan.com	