Authorization for the Release of Protected Health Information

Member Name: ____

Address: ____

Telephone Number: ___________________________ Member ID Number: ______________________________

I authorize the following Protected Health Information to be disclosed (Select all that applies):

☐ My claim information:

- ☐ All dates of service
- ☐ The following dates of services __________________

☐ Dependant(s) claim information (Name the dependant(s)):

____

- ☐ All dates of service
- ☐ The following dates of services __________________

☐ Financial Information.

☐ Appeal status or information.

☐ Plan or benefit coverage information.

☐ Any other information regarding my account and/or dependant(s).

I authorize Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. to release the Protected Health Information explained above to the following entity. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims. I understand that if this person or organization is not a health plan or other entity subject to federal privacy laws, they may further disclose my information and the information may no longer be protected by federal privacy laws.

Name of Organization or Individual: ____

Address: ____

Phone Number: ____

This authorization will automatically expire on ___ / ___/ ___.

(Please note that even if a specific date is given this authorization will expire no later than six months after termination of enrollment with Dominion.)

☐ Termination of enrollment with Dominion

☐ Six months after termination of enrollment with Dominion

I, ____, have had full opportunity to read and consider the content of this authorization form. I understand that, by signing this form, I am confirming my authorization that Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. may use and / or disclose my protected health information to the person or entity named on this form for the purpose described above. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to revoke this authorization at any time. I understand that revocation of this authorization will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the following entity: Dominion Dental Services, Inc; Attention: Privacy Officer; 115 South Union Street, Suite 300; Alexandria, Virginia 22314.

Signature: ____________________________________ Date: _______________________

If a person other than the Member signs this form, please complete the following:

Personal Representative's Name: ____

Relationship to the Individual: ____

Please return this completed authorization, or direct any questions regarding the form, to the following individual:

Privacy Officer – Dominion Dental Services, Inc.
115 South Union Street, Suite 300, Alexandria, Virginia 22314
(703) 518-5000
Privacycoordinator@dominiondental.com