Request and Authorization for Disclosure of Health Information

PLEASE PRINT or TYPE

EFFECTIVE AS OF _____

This is an authorization requesting _____ [Name of Health Plan-organization that will release your information] to release individual health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or by state law protecting the privacy of health information. I hereby authorize the use and disclosure of the individually identifiable health information as described below.

(1) The request for release of information is being made **for** the dental plan member identified below.

_____ _____ ___/___/_____
Identification Number Member's Name Date of Birth

_____ (___)____-_____
Mailing Address Telephone Number

(2) Specific description of information that may be used/disclosed:

☐ Claims Information ☐ Payment Information

☐ Other Information (must provide specific description): _____

_____

(3) The information will be used/disclosed for the following purpose(s):

☐ Obtaining Claims Information or Payment Information for the Resolution of Claim Processing or Payment Issues

☐ Other: _____

(4) Persons/organizations **authorized to receive** the information:

☐ Family Members (must list name and relationship): _____

_____ _____ _____

☐ All Group Health Plan Representatives at member's place of employment (provide name of member's employer): _____

☐ Other (must list names and relationship to member): _____

_____

(5) I understand that I may revoke this authorization at any time by sending a written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action your dental plan or it's subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, my dental plan may not use or disclose my health information for any reason except those described in Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date.

This authorization expires on ____/____/_____. [Insert applicable date. If no expiration date is stated, this authorization will be deemed to expire one year from the date of execution.]

I understand that authorizing the disclosure of this health information is voluntary, and is not a condition of enrollment in this health plan's eligibility for benefits, or payment of claims.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I release my dental plan, its affiliated companies, employees, officers and business associates from legal liability for any recipient's use or disclosure of information released by my dental plan in reliance on this authorization.

_____ _____

Signed (member or personal representative) Date

_____

Printed name of signature above (member's personal representative)

_____

Description of the representative's authority to act for the member

You are entitled to a copy of this authorization after you sign it. Any revocation or change to this authorization, or any questions regarding its legal effect, should be addressed to:

Dental Customer Service
P.O. Box 69420
Harrisburg, PA 17106-9420

If you have any questions, please call Dental Customer Service at the telephone number located on the back of your identification card. You may fax this form to 1-866-335-3969 or return the form to the address listed above.

Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, ancestry, age, religion, disability, marital status, gender, sex assigned at birth, sexual orientation, sex stereotypes, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 1-800-332-0366 (TTY: 711) for assistance or contact the Civil Rights Coordinator at: P.O. Box 22492, Pittsburgh PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, religion, disability, marital status, gender, sex assigned at birth, sexual orientation, sex stereotypes, gender identity or recorded gender you can file a grievance with the Plan. Grievance forms and a description of the grievance procedure are available directly from United Concordia by calling Customer Service at 1-866-357-3304, in the Form's section of United Concordia's website at *www.unitedconcordia.com* and at each contracted provider's facility, and are provided promptly upon request. If you need help filing a grievance, call Customer Service at 1-866-357-3304 for assistance.

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1 866-357-3304** (and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online."

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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California Department of Insurance
Consumer Services Division
300 S. Spring Street
Los Angeles, CA 90013
1-800-927-4357

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

English	ATTENTION: If you speak English, you have the right to language assistance services at no charge to you, including interpretation services and translated written documents in your preferred language. Call 1-800-332-0366 (TTY: 711) for assistance.
Español (Spanish)	ATENCIÓN: Si habla español, tiene derecho a servicios de asistencia lingüística sin coste alguno, incluidos servicios de interpretación y traducciones de documentos escritos en la lengua que desee. Llame al 1-800-332-0366 (TTY: 711) para más información.
繁體中文 (Chinese)	注意：如果您的語言是繁體中文，您有權免費使用語言協助服務，包括以您偏好的語言提供的口譯服務和翻譯的書面文件。如需協助，請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	LƯU Ý: Nếu quý vị nói Tiếng Việt, bạn sẽ có quyền hưởng miễn phí dịch vụ hỗ trợ ngôn ngữ, bao gồm dịch vụ phiên dịch và tài liệu bằng văn bản được dịch sang ngôn ngữ bạn chọn. Gọi điện đến số 1-800-332-0366 (TTY: 711) để được hỗ trợ.
Tagalog (Tagalog)	PANSININ: Kung nagsasalita ka ng Tagalog, may karapatan ka sa mga serbisyong tulong sa wika nang wala kang babayaran, kabilang ang mga serbisyo sa pagsasalin at mga nakasulat na dokumento na naisalin sa iyong pinipiling wika. Tumawag sa 1-800-332-0366 (TTY: 711) para sa tulong.
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 원하는 언어로의 번역 서비스 및 번역된 서면 문서를 포함하여, 언어 지원 서비스를 무료로 사용할 수 있습니다. 도움이 필요하면 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Հայերեն (Armenian)	ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Դուք հայերեն եք խոսում, Դուք իրավունք ունեք անվճար ստանալ լեզվական աջակցության ծառայություններ, այդ թվում նաև՝ բանավոր թարգմանության և փաստաթղթերի գրավոր թարգմանության ծառայություններ՝ Ձեր նախընտրած լեզվով: Օգնություն ստանալու համար զանգահարեք 1-800-332-0366 (TTY՝ 711) հեռախոսահամարով:
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، حق دارید از خدمات تسهيلات زبانی بصورت رايگان استفاده کنید، از جمله خدمات ترجمه شفاهی و اسناد کتبی ترجمه شده به زبان انتخابی خودتان. با 1-800-332-0366 (تله تایپ: 711) تماس بگيريد
Русский (Russian)	ВНИМАНИЕ: Пользователям, разговаривающим на русском языке, бесплатно предоставляются службы языковой поддержки, включая услуги устного перевода и письменного перевода документов на предпочитаемый язык. Тел. службы поддержки 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。サービスには、選択された言語による通訳や文書の翻訳も含まれます。サポートが必要な場合は、1-800-332-0366 (TTY: 711)まで、お電話にてご連絡ください。
العربية (Arabic)	تنبيه: إذا كنت تتحدث العربية، لديك الحق في الحصول على خدمات المساعدة اللغوية مجانًا، بما في ذلك خدمات الترجمة والمستندات المكتوبة المترجمة بلغتك المفضلة. اتصل على الرقم 1-800-332-0366 (خدمة الرسائل النصية: 711) للحصول على المساعدة.
ਪੰਜਾਬੀ (Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਲੈਣ ਦਾ ਹੱਕ ਹੈ, ਜਿਸ ਵਿੱਚ ਤੁਹਾਡੀ ਪਸੰਦ ਦੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਅਤੇ ਅਨੁਵਾਦ ਕੀਤੇ ਗਏ ਲਿਖੇ ਹੋਏ ਦਸਤਾਵੇਜ਼ ਸ਼ਾਮਲ ਹਨ। ਸਹਾਇਤਾ ਲਈ 1-800-332-0366 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ।
កម្ពុជា (Cambodian)	ប្រការត្រូវចងចាំ៖ ប្រសិនបើលោកអ្នកនិយាយភាសាអង់គ្លេស លោកអ្នកមានសិទ្ធិទទួលបានជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នកដោយរួមបញ្ចូលទាំងសេវាកម្មបកប្រែផ្ទាល់មាត់ និងឯកសារដែលបានបកប្រែជាលាយលក្ខណ៍អក្សរជាភាសាដែលលោកអ្នកពេញចិត្ត។ សូមហៅមកកាន់លេខ 1-800-332-0366 (TTY: 711) ដើម្បីទទួលបានជំនួយ។
ຊົນເຜົ່າລາວສູງ (Hmong)	ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາມົ້ງ, ທ່ານມີສິດໄດ້ຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ເຊິ່ງລວມມີການບໍລິການລ່າມແປພາສາ ແລະ ການແປເອກະສານເປັນລາຍລັກອັກສອນເປັນພາສາທີ່ທ່ານເລືອກ. ກະລຸນາໂທຫາເບີ 1-800-332-0366 (TTY: 711) ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ.
हिंदी (Hindi)	ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपको बिना किसी शुल्क के भाषा में सहायता संबंधित सेवाएँ प्राप्त करने का अधिकार है, जिसमें शामिल हैं इंटरप्रेटर की सेवाएँ और आपकी पसंदीदा भाषा में अनुवादित लिखित दस्तावेज़. सहायता के लिए 1-800-332-0366 (TTY: 711) पर कॉल करें.
ไทย (Thai)	โปรดทราบ หากภาษาพูดของคุณคือภาษาอังกฤษ คุณมีสิทธิที่จะได้รับความช่วยเหลือทางด้านภาษาโดยไม่มีค่าใช้จ่ายใด ๆ รวมถึงการบริการด้านล่ามและการแปลเอกสารที่แปลเป็นภาษาที่คุณต้องการ หากต้องการความช่วยเหลือ กรุณาติดต่อ 1-800-332-0366 (TTY: 711)