

***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](mailto: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](http://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>

## **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.

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 complaint with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmark.com](mailto:CivilRightsCoordinator@highmark.com). You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, the Civil Rights Coordinator is available to help you. You can also file a complaint with the California Department of Insurance electronically through the Consumer Complaint Center, available at <http://www.insurance.ca.gov/01-consumers/101-help/index.cfm>, or by mail or phone at:

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>

