

***Request and Authorization for Disclosure of Health Information***

***PLEASE PRINT or TYPE***

***EFFECTIVE AS OF*** \_\_\_\_\_

This is an authorization requesting United Concordia Companies, Inc. or its subsidiary as shown on the list below (UCCI) 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

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Member's Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Mailing Address

- (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 names and relationship): \_\_\_\_\_

\_\_\_\_\_

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 UCCI or its 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, UCCI may not use or disclose my health information for any reason except those described in UCCI's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event, or circumstance.

***This authorization expires on [upon] \_\_\_\_\_.***  
***[Insert applicable date, event or circumstance. If no expiration 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 that I can refuse to sign this authorization.

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

\_\_\_\_\_  
Signed (Member or personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of signature above (member/patient or patient's personal representative)

\_\_\_\_\_  
Description of the representative's authority to act for the member/patient

**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:**

United Concordia Companies, Inc.  
TDP Customer Service  
P.O. Box 69410  
Harrisburg, PA 17106 – 9410

If you have any questions, please call TDP Customer Service at 1-800-866-8499.