Access Dental Plan
P.O. Box 659005
Sacramento, CA 95865-9005

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Name of Member:_____ I.D. Number: _____

Address of Member: _____

I authorize **Access Dental Plan** to use and disclose a copy of the specific health and dental information described below.

Information consisting of: *(Check all that apply.)*

❒ Eligibility ❒ Benefits ❒ Claims ❒ Prior Authorizations/Specialty Referrals

❒ Other (*Please specify*) _____

Name of the Person(s) or Organization(s) to whom you authorize us to use or disclose your information:

Please check all that apply, and list the name or organization:

❒ Spouse _____ ❒ Mother _____

❒ Employer _____ ❒ Father _____

❒ Child _____ ❒ Other _____

For the purpose of: *(Describe intended use or purpose of this disclosure)*

_____

_____

Expiration of Authorization: *(For how long do you wish this Authorization to last)*

❒ 1 year ❒ 3 years ❒ 5 years ❒ No expiration ❒ Other _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date: _____
Signature of Member (*or authorized representative, if Member is a minor*)

Printed Name of Authorized Representative _____

Relationship to Member _____

Please mail this form to the above-mentioned address to the attention of Customer Service. You may also FAX the form to (916) 646-9000 to the Attention of Customer Service.

FOR INTERNAL USE ONLY		
Date Received	Entered into Member's Record By	Date original given to Privacy Officer