DELTA DENTAL®

INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual that Delta Dental of Virginia use or disclose protected health information for a particular purpose. This form is to be used for individuals enrolled in a fully-insured ("RISK") or self-insured ("Administrative Services Only") group health plan.

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

I authorize the use and/or disclosure my protected health information as described in Section C below**.** I understand this authorization is voluntary and made to confirm my direction.

Name: _____ Group #_____

Address: _____

Telephone: _____ E-mail: _____

Subscriber Number: _____ Social Security Number: _____

SECTION B: The use and/or disclosure being authorized.

Protected Health Information to Be Used and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (i.e. Claims, Enrollment, Eligibility, etc.):

_____

_____

_____

Entities Authorized to Use or Disclose: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), **including Delta Dental of Virginia**, who you are authorizing to make use of and/or to disclose the protected health information described above. With respect to Delta Dental of Virginia, please identify the class of representatives that are authorized to receive Protected Health Information including benefit services, billing, or eligibility and enrollment.

_____ _____

_____ _____

Entities Authorized to Receive and Use: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing Delta Dental of Virginia to disclose and/or let use the protected health information described above:

_____ _____

_____ _____

Description of Each Purpose of the Protected Health Information to be Used and/or Disclosed: Specifically and meaningfully describe each purpose of the protected health information you are authorizing to be used and/or disclosed, or write "at the request of the individual" if you elect not to provide a statement of the purpose(s):

_____

_____

_____

_____

SECTION C: Expiration and Revocation.

Expiration: In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits, this authorization may not exceed thirty months from the date the authorization is signed.

In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits, this authorization may not exceed the duration of the claim.

The authorization will expire (complete one):

☐ On ____/____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

_____

_____

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Delta Dental of Virginia. I understand that, by signing this form, I am confirming my authorization that Delta Dental of Virginia may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described in this form 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 or state privacy laws.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

RETURN COMPLETED FORM TO: Delta Dental of Virginia, Attention: Compliance Officer, 4818 Starkey Road, Roanoke, VA 24018, Telephone: (540) 989-8000, Toll-free: (800) 237-6060; Fax: (540) 491-9710.

YOU AND YOUR PERSONAL REPRESENTIVE ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.