



Authorization for the Release of Protected Health Information

Member Name: _____

Address: _____

Telephone Number: _____ Member ID Number: _____

I authorize the following Protected Health Information to be disclosed (Select all that applies):

My claim information: Dependant(s) claim information (Name the dependant(s)):

All dates of service

The following dates of services _____

All dates of service

The following dates of services _____

Financial Information.

Plan or benefit coverage information.

Appeal status or information.

Any other information regarding my account and/or dependant(s).

I authorize Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. d/b/a Dominion National to release the Protected Health Information explained above to the following entity. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims. I understand that if this person or organization is not a health plan or other entity subject to federal privacy laws, they may further disclose my information and the information may no longer be protected by federal privacy laws.

Name of Organization or Individual: _____

Address: _____

Phone Number: _____

This authorization will automatically expire on ___ / ___ / ___.

Termination of enrollment with Dominion

(Please note that even if a specific date is given this authorization will expire no later than six months after termination of enrollment with Dominion.)

Six months after termination of enrollment with Dominion

I, _____, have had full opportunity to read and consider the content of this authorization form. I understand that, by signing this form, I am confirming my authorization that Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. d/b/a Dominion National may use and / or disclose my protected health information to the person or entity named on this form for the purpose described above. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to revoke this authorization at any time. I understand that revocation of this authorization will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the following entity: Dominion National; Attention: Privacy Officer; 251 18th Street South, Suite 900; Arlington, VA 22202.

Signature: _____ Date: _____

If a person other than the Member signs this form, please complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Please return this completed authorization, or direct any questions regarding the form, to the following individual:

Privacy Officer – Dominion National
251 18th Street South, Suite 900, Arlington, VA 22202
703.518.5000
PrivacyCoordinator@DominionNational.com