Avalon℠

DOMINION® DENTAL Services, Inc.

Member Authorization Form To Release Information

Dear Member,

The enclosed form is used to obtain authorization from the member whose information will be released, or from the member's personal representative, to disclose the member's information to an individual or organization not otherwise authorized to receive this information.

This form is also used to obtain specific authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse.

PRIVACY OFFICE • 115 SOUTH UNION STREET • SUITE 300 • ALEXANDRIA, VA 22314-3362

dominiondental.com

Directions for Completing the Member Authorization Form To Release Information

This form is used to obtain authorization from the member, or the member's personal representative, to disclose the member's information to an individual or organization not otherwise authorized to receive this information. This form is also used to receive member authorization to use or disclose a member's psychotherapy notes or to disclose member information related to HIV, mental health, or substance abuse. This form may only be signed by the member or the member's "personal representative" (see description of personal representative below).

PLEASE PRINT

Member Information: Complete all information requested in this section for the member whose information will be released.

Important: Name, Address, ID Number, and Date of Birth are required.

- **ID Number:** List each identification number shown on the member's identification card(s) that would apply to this authorization.

Authorization: There are two sections here.

Section I: The first section must always be completed. You must identify the individual(s) or organization(s) to receive the information. Describe the information as specifically as possible. If more space is needed to describe the information, use the back of the form. Next, describe why this information is being disclosed or check "This information is being disclosed at the request of the member or the member's personal representative." If no Purpose of Disclosure is given, Avalon® Insurance Company and Dominion Dental Services, Inc. will assume that this information is being disclosed at the request of the member or the member's personal representative.

Section II: The second section is to be completed only if the information to be used or disclosed includes psychotherapy notes, or if the disclosure involves HIV, mental health, or substance abuse information.

If this authorization is being used for psychotherapy notes, it can only be used for that specific purpose and no other.

Psychotherapy notes are defined in the Health Insurance Portability and Accountability (HIPAA) Privacy Rule as:

> *Notes made by a mental health professional that document or analyze the contents of conversations during counseling sessions, which are kept separate from the rest of the member's medical record, and* ***exclude*** *medication, prescription, monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.*

Expiration and Revocation: Expiration information must be completed for an authorization to be valid. Check one of the three boxes provided to show when you want this authorization to expire. If you check the "This specific date" box, you must write in a specific date. If no expiration box is checked, this form will expire six months after termination of enrollment.

To revoke this authorization form, contact our Privacy Office at 888.681.5100, 703.518.5000, or privacycoordinator@dominiondental.com.

Personal Representative Information: A personal representative is the member's legal guardian or someone who has power of attorney over the member's health care decisions, or a parent, if the member is a dependent child under the age of 18 and not an emancipated minor. Also, a personal representative can be an executor, administrator, or person legally authorized to act on behalf of a deceased member or the member's estate. Other than a parent acting on behalf of a dependent child, under the age of 18 who is not an emancipated minor, we require a copy of the power of attorney or other court-initiated document as proof that the individual named should be recognized as the member's personal representative. For this form to be processed, it is important that a copy of any applicable power of attorney or other court-initiated document is included when you return this form to our Privacy Office.

Signature/Date: The member whose information will be released, or the member's personal representative, must sign and date this form for it to be processed.

If you have questions about this form, please contact us at 888.681.5100, 703.518.5000, or privacycoordinator@dominiondental.com.

Unless directed otherwise, please return this completed and signed form to:

Privacy Office
115 South Union Street
Suite 300
Alexandria, VA 22314-3362

Avalon℠

Member Authorization Form To Release Information

DOMINION® DDS DENTAL Services, Inc.

This form is used to obtain authorization to disclose a member's information to an individual or organization not otherwise authorized to receive it. Also, this form may be used to request the use of a member's psychotherapy notes. **This form may only be signed by the member, whose information will be released, or by the member's "personal representative."** Refer to "Directions for Completing the Member Authorization Form To Release Information" for a description of "personal representative." When completing this form, please print.

Member Information: (Name of Member Whose Information Will Be Released)

Name: (First, Middle Initial, Last, Title {Sr., Jr., III.})	**Date of Birth:** (Month/Day/Year)
Address: (Including ZIP Code)	**Telephone Number:** (Including Area Code) (Optional)

ID Number: (List each identification number shown on the member's identification card(s) that would apply to this authorization.)

Authorization: Section I must be completed for all authorizations. Section II must be completed only if member information related to HIV/AIDS, mental health, or substance abuse is to be disclosed, or if psychotherapy notes are used or disclosed.

Section I: (Please check all applicable boxes)

❑ **I authorize Avalon Insurance Company, Dominion Dental Services, Inc., and their assignees and affiliates to disclose the above individual's protected health information to:**

Name _____ Telephone Number _____

Address _____

(You must include the name, address, and telephone number of the person(s) or organization(s) receiving the member information. If additional person(s) or organization(s) are being authorized, list the name, address, and telephone number for each on the back of this form.)

Description of the information to be disclosed: (If more space is needed to describe the information to be released, use the back of this form.)

❑ All claims and appeals
❑ Billing/enrollment
❑ Specific claims: (specify date(s) of service, claim number(s), etc.)
❑ Other: (please specify) _____

_____ _____

Purpose of Disclosure: (Please describe the reason why this information is needed or check the following:

❑ This information is being disclosed at the request of the member or the member's personal representative.

_____

_____

If no purpose of disclosure is given, then Avalon Insurance Company, Dominion Dental Services, Inc., and their assignees will assume that this information is being disclosed at the request of the member or the member's personal representative.

Section II: I understand that specific authorization is needed to release member information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case:

HIV/AIDS _____ (Initials)
Mental Health _____ (Initials)
Substance Abuse _____ (Initials)
Psychotherapy Notes _____ (Initials)

(See "Directions for Completing the Member Authorization Form To Release Information" for a description of psychotherapy notes.)

Expiration and Revocation: One of the following expiration boxes must be checked.

Expiration: This authorization will expire on:

❑ This specific date_____/____/_____
❑ Termination of enrollment
❑ Six months after termination of enrollment

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

If no expiration box is checked, then this form will expire six months after termination of enrollment.

Right to Revoke: You may revoke this authorization form at any time. Contact our Privacy Office for further instructions. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Personal Representative Information: Complete this section if a personal representative is authorizing disclosure of the member's information. See "Directions for Completing the Member Authorization Form To Release Information" for information and directions about personal representatives. A copy of a power of attorney or other court-initiated document will be required, if applicable.

Name: (First, Middle Initial, Last, Title {Sr., Jr., III.})	**Relationship to the Member:**
Address: (Including ZIP Code)	**Telephone Number:** (Including Area Code)

Signature/Date: The member whose information will be released, or the member's personal representative, must sign and date this form for it to be processed.

I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not 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 understand that authorizing the use and disclosure of member information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

Signature: _____ **Date:** _____

❑ Please check this box if you would like to receive a copy of this form.

Unless directed otherwise, please return this completed and signed form to:

Privacy Office
115 South Union Street
Suite 300
Alexandria, VA 22314-3362