LIBERTY DENTAL PLAN

Authorization for Release of Health Information

Enrollee's Full Name:

Enrollee's Street Address:

City:	State:	Zip Code:

I understand and agree that:

- This authorization is voluntary.
- My Health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease, and health care program information.
- I will not be denied treatment if I do not sign this form.
- I will not be denied payment for health (dental) care services if I do not sign this form.
- I will not be denied enrollment or eligibility for health care benefits if I do not sign this form.
- The recipient of my health information could disclose it to other parties who are not included in this authorization.
- If parties are not health (dental) plans or health (dental) providers, then the information may no longer be protected by federal privacy regulations.
- I may revoke this authorization at any time by calling LIBERTY Dental Plan at: 1.833.276.085, by writing LIBERTY Dental Plan, P.O. Box 15149, Tampa, FL, 33684 or sending a fax to: 1.888.700.1727.
- The revocation will not influence my dental care.

Who May Receive and Disclose my information:

I authorize LIBERTY dental plan and its affiliates to disclose my individual identifiable health information to the following person(s) or organization(s):

_____

Full Name of Person(s) or Organizations

_____

Address and/or Phone Number of Person(s) or Organizations(s)

Type of information to be disclosed: Please check one

☐I authorize disclosure of all my health information, including information relating to claims, dental, medical, pharmacy, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease; or

☐I authorize only the disclosure of the following information:

_____

(Type of Information)

Purpose of Disclosure: Check one

☐My health information is being disclosed at my request or at the request of my personal representative; or

☐My health information is being disclosed for the following purpose:

_____

(Explain Purpose)

_____

Signature of Enrollee or Representative *Date*

_____

Print name of Enrollee or Representative *Date*

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the enrollee