SECURECARE DENTAL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFO

PATIENT / MEMBER

Name ____
Last | First | Middle Initial

Date Of Birth – Month, Day, Year ______________________

Member ID Number ______________________

Phone ______________________

Relationship to Subscriber ______________________

RELEASE TO

I hereby authorize SecureCare Dental to release or disclose information related to my dental benefits/care or that of my minor child, to:

Name and address of individual, agency or organization to which information is to be released:

Name ______________________

Company ______________________

Address ______________________

Phone ______________________

INFORMATION

Describe information to be released:

Date From ______________ To ______________

Information: ______________________

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Reason for release of Information:

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SIGNATURE

I understand that this authorization, except for action already taken, may be revoked by me at any time. Unless revoked, this authorization will remain in force for 180 days from the date below. I understand there is potential for re-disclosure of this information, and that SecureCare Dental may not be held responsible for such re-disclosure. A photocopy of this authorization is to be accepted with the same authority as this original.

Signature of member/parent/guardian: ______________________

Printed Name ______________________ Date: ______________

Staff Review by: ______________________

Privacy Officer Review: ______________________

3625 North 16th Street, Suite 206; Phoenix, AZ 85016 Phone: (602) 241-0914 Fax: (602) 285-0121