

HIPAA Authorization for Release of Protected Health Information – UDC Dental California, Inc.



Insured/Member name _____ ID no. _____

Address _____ City _____ State _____ Zip code _____

Policy no. _____ Participation no. _____

Account no. _____ Certificate no. _____

Persons/organizations providing the information:

- Union Security Insurance Company
- Union Security Life Insurance Company of New York
- Other (*Please specify.*)

Persons/organizations receiving the information:

- UDC Dental California, Inc.

Treating dentists, hygienists, dental office staff

I hereby authorize the use of disclosure of my protected health information as described below.

Specific description of information to be disclosed Dental records including chart notes, narratives, clinical examination findings/diagnoses, radiographs, treatment plans, billing statements, and claim submissions.

Purpose of the disclosure To determine eligibility, make a determination of benefits, adjudicate a claim, and/or resolve a complaint.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that the Companies may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under one of the Companies' insurance policies. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Assurant Employee Benefits, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.

Products marketed by Assurant Employee Benefits are underwritten and/or provided by UDC Dental California, Inc.

- Federal law requires that we inform you that the information that we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.
- This authorization is effective from the date signed below until _____.

DATE OR EVENT (NOT TO EXCEED 24 MONTHS)

SIGNATURE OF INSURED/MEMBER OR PERSONAL REPRESENTATIVE

DATE

(Form MUST be completed before signing.)

Printed name of personal representative _____

Relationship to insured/member _____

(E.G. LEGAL GUARDIAN, POWER OF ATTORNEY, SPOUSE, RELATIVE, ETC.)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization for processing to the address listed below:

UDC Dental California, Inc.,
6310 Greenwich Drive, Suite 210,
San Diego, CA 92122
fax 858.678.0692