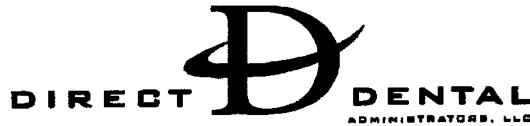

Authorization For Release of Information to Direct Dental Administrators to process Dental Claims

I hereby authorize the use or disclosure of my individually identifiable health information to Direct Dental Administrators, LLC as needed to review, investigate or evaluate any claim for benefits under the dental plan. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Employee name:______________________________ Social Security #:____________

Specific description of information to be used or disclosed (including date(s)): Dental Records, charting, xrays or treatment notes pertaining to dental claims submitted to Direct Dental.

Specific purpose of the disclosure: To assist in processing dental claims.

The authorization will expire 5 years from this date.

I. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

II. Signature of Employee:

_________________________________ _________________________________

Signature of Employee Date

(Form Must be completed before signing.)

P.O. BOX 2667 SAN ANSELMO, CA 94979-2667
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