MetLife®

Re: Voluntary Release of Information

Dear Dental Plan Participant,

At MetLife, we are dedicated to protecting your right to privacy. That is why if you would like to authorize someone, such as a spouse, relative, or a friend to help you with matters concerning your dental benefits, we ask you to review and complete the enclosed authorization and return it to us at:

MetLife
PO Box 14587
Lexington, KY 40512

Note that the completion and return of this authorization is completely voluntary. This will allow us to release information about your dental benefits, including health information to the person(s) specified. Please remember this concerns your personal records and can only be signed by you or your legal representative (such as a power of attorney, guardian or conservator).

If you have any questions, please call us toll free at **1-800-942-0854 Monday through Thursday, 7:00 AM to 7:00 PM (EST) and Friday 7:00 AM to 5:00 PM (EST).** A MetLife customer service representative will be happy to assist you. Thank you for choosing MetLife.

Sincerely,

MetLife Dental Program Management

MetLife®

HIPAA* AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please Print Clearly and Complete in its Entirety.

I hereby authorize Metropolitan Life Insurance Company (MetLife) to disclose Personal Health Information about me relating to my coverage under the following benefit plan:

DENTAL
Administered by: MetLife PO Box 14587 Lexington, KY 40512

Disclosure is initiated by me and authorized for the following purpose/reason: (you must check one)

- ❑ To assist me in my inquiry about claims or other activities related to my dental benefits.
- ❑ I elect not to provide a statement of purpose/reason. Please make the disclosure at my request.
- ❑ Other purpose/reason – describe in detail.

_____

_____

Personal Health Information to be disclosed: (you must complete one of the following)

- ❑ I authorize MetLife to release my personal health information relating to my dental benefits (including billing, claim and plan information).

OR:

- ❑ Please provide a detailed description. MetLife will not make a disclosure unless the information requested to be disclosed is specifically identified.

_____

_____

COVERED PERSON - NAME (print) First	Middle	Last	Employee SSN or ID #
Address	City	State	Zip Code	Group # (if applicable)

Name and address of person or entity authorized to receive the specified Personal Health Information:

_____

_____

By signing below, I acknowledge and understand that:

- This authorization is voluntary.
- I may revoke this authorization at any time by writing to MetLife at the address above. If I do not revoke this authorization, it will be valid until such time as I am no longer covered under this dental benefit plan. My revocation will not apply to any action taken before MetLife receives it.
- Personal Health Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.

Signature of Covered Person or Personal Representative of the Covered Person: _____ **Date:**_____

If signed by Personal Representative of the Covered Person, please describe the authority under which the Personal Representative is authorized to act:

_____

_____

* This Authorization has been designed to comply with applicable requirements of Federal Privacy rules under the Health Insurance Portability and Accountability Act (HIPAA).