PREMIER ACCESS
QUALITY DENTAL PLANS

Premier Access Insurance Company
P.O. Box 659020
Sacramento, CA 95865-9020

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Name of Member: _____I.D. Number: _____

Address of Member: _____

I authorize **Premier Access Insurance Company** to use and disclose a copy of the specific health and dental information described below regarding:

For the Purpose of:
Please disclose my dental records for the purpose of: (check one)
□ Claims Status □ Eligibility □ Prior Authorizations □ All Listed

Name of the Person(s) or Organization(s) to whom you authorize us to use or disclose your information:
Please check all that apply, and list name or organization:
□ Spouse _____ □ Mother _____ □ Father _____
□ Employer _____ □ Dental Provider_____
□ Other _____

Expiration Date of Authorization: (For how long do you wish this Authorization to last):
□ Until issue or claim is resolved □ 1 year □ Until Eligibility terminates
□ Other _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date: _____
Member's Signature
Or By:_____ Date: _____
Member's Representative's Signature ***(such as a parent of a minor, guardian, foster parent)***

Description of Representative's Authority _____

Please mail this form to the above-mentioned address to the attention of Angela Ceasar. You may also FAX this form to (916) 646-9000 to the Attention of Angela Ceasar.

FOR INTERNAL USE ONLY:
Authorization Received on: _____ *Entered into Member's Record by:*_____

Original given to Privacy Officer on _____