MEMBER OR MEMBER'S DEPENDENT -

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please Print Clearly and Complete in its Entirety.

Member Name: _____

Address: _____

City: _____ Zip: _____
tate: _____

Home Telephone Number: ( ) -

DOB:

Policy/Group Number: _____

Subscriber Number: _____

Disclosure is initiated and authorized by me for the use or disclosure of protected health information by Beam Dental for the purpose/reason. (you must check one)

- ❑ To assist me in my inquiry about claims or other activities related to my dental benefits.
- ❑ At the request of the above individual.
- ❑ Other purpose/reason – describe in detail.

Please describe the information to be disclosed in a specific and detailed manner below:

Authorization is effective for the following:

- ❑ Claim(s) only Claim # _____ Claim # _____
- ❑ Valid until I am no longer covered under this dental benefit plan
- ❑ For the following dependents (under the age of majority or lack capacity)*:
  1._____
  2._____
  3._____
  4._____

  * person or entity you are authorizing to receive access will have access to the same information for all dependents. If you would like to provide different authorization for each dependent, a separate form needs to be completed for each.

  If you have more than 4 dependents, please use a separate form to complete.

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 understand that the Plan may not condition treatment, payment, enrollment or eligibility for benefits on my executing this authorization.
- I may revoke this authorization at any time by emailing support@beamdental or calling 1-800-648-1179. Please note the revocation must be in writing. Authorization remains in effect until Beam Dental receives and processes the complete and signed revocation. If I do not revoke this authorization, it will be valid until I am no longer covered under this dental benefit plan.
- 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 Member or Covered Person or
Personal Representative of the Member or Covered Person:_____Date:_____

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