SafeGuard

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT OR TYPE ALL RESPONSES

Your request for release of information cannot be processed if the form is not completed in its entirety.

Date: ____________________________

Member Name: ____

Member Address: ____

Member Phone Number: (Day) ____

Member Identification Number: ____

Patient Name: ____

Patient Address: (if different than member) ___________________________________

____

I authorize the individual or company identified below to receive confidential protected health information pertaining to the member or patient identified above.

Name: ____

Street Address: ____

City, ST & Zip: ____

Telephone Number: (Daytime, include area code) _(___)_____________________________

In accordance with any applicable state and federal law, I hereby authorize SafeGuard to release information relating to:

_____ Claims/status **____ Billing/eligibility** **____ dental services/treatment**

Other: please specify ____

____

____

SafeGuard

Subject to limitation(s), if applicable: ____

I acknowledge that, in accordance with the law, the information authorized for release may include information regarding communicable or venereal diseases. It may also include behavioral conditions, including alcohol and substance abuse and/or genetic marker information.

IMPORTANT: If this information is being authorized by a legal representative, a copy of power of attorney, or any official document that provides the designation must be attached to this document.

I understand this authorization is voluntary and made to confirm my decision and directions. I understand that by signing this document, I will be holding SafeGuard harmless from any claim or liability that is associated with the release of the information permitted within this document. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law. In addition, I further understand that if there is a fee associated with this disclosure, I am responsible for payment in accordance with notification of the amount, method of payment and due date.

This Authorization shall be in force and effect until (1) one year days following the date indicated below, or (2) the date of the event that relates to the patient or the purpose of the use or disclosure, at which time this authorization to use or disclose this Protected Health Information expires.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Privacy Officer, SafeGuard, 95 Enterprise, Suite 100, Aliso Viejo, CA 92656-2605. I understand that a revocation is not effective until receipt of notice of revocation by SafeGuard.

____

(Print) Name of Member/Patient/Legal Representative

____

Signature of Member/Patient/Legal Representative

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Relationship to Patient. If patient is under 18 years of age, a parent or legal guardian must sign this authorization.

____

Date