DDS
inc.
265 Post Avenue – Suite 340, Westbury, NY 11590
516.794.7700 Fax 516.794.7762 www.ddsinc.net

DDS INC. PHI Authorization Form

Request for DDS Inc. to disclose PHI for:

Member Social Security # ____________________________ Relationship to Member ____________________
(Self, spouse or dependent)

Name ____ ______________________________ __________
(Last) (First) (Mid. Init)

Plan Sponsor ____
(group name or local union #)

Authorized Individual:

I authorize DDS Inc. to disclose my PHI to the following individual:

Name ____ ________________________________ __________
(Last) (First) (Mid. Init)

Address
____

Relationship to Patient ____

Purpose or use of disclosure:

The purpose(s) for which the authorized individual named above may have access to my PHI (check all that apply)

any purpose		coordination of benefits		eligibility		dental claims or appeals	
payment or billing		coverage		preauthorization		limitations, exclusions or co-payments	

other (please explain) ____

Effective Period of this Form:

This authorization is valid for the period shown below: (Check only one)

____ as long as I am eligible for dental benefits under my current plan sponsor

____ only until the information requested is provided to the individual authorized on this form

____ until ____ (provide a date or event)

____ until I cancel it by submitting a *Cancellation of Authorization* Form

I acknowledge that I had full opportunity to read and consider the contents of this Authorization form and the DDS Notice of Privacy Practices. (enclosed) I understand that by signing this form I am authorizing DDS Inc. to use & disclose my PHI to the individual listed as the authorized individual. I further acknowledge that this individual may not be required to treat this information as confidential.

Signature ____ Date ________________________

YOU ARE ENTITLED TO A COPY OF THIS FORM AFTER YOU SIGN IT.

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PURPOSE OF THIS FORM- Effective April 14, 2003 the Dept. of Health & Human Services, under the HIPAA regulations, has changed the standards on the use & disclosure of dental records. In order for DDS Inc to use or disclose your Protected Health Information (**PHI**) to someone other than yourself you must complete this authorization form and return it to the address above. Except as permitted by law DDS Inc. may not disclose your PHI to individuals other than those you specify on this form.