HIPAA Authorization for Release of Protected Health Information—UDC Dental California, Inc.

Sun Life Financial®

Insured/Member name _____ ID no. _____

Address _____ City _____ State _____ Zip Code _____

Policy no. _____ Participation no. _____

Account no. _____ Certificate no. _____

Persons/organizations providing the information:

☒ Other *(Please specify.)*

Treating dentists, hygienists, dental office staff

Persons/organizations receiving the information:

☒ UDC Dental California, Inc.

I hereby authorize the use or disclosure of my protected health information as described below.

Specific description of information to be disclosed Dental records including chart notes, narratives, clinical examination findings/diagnoses, radiographs, treatment plans, billing statements, and claim submissions.

Purpose of the disclosure To determine eligibility, make a determination of benefits, adjudicate a claim, and/or resolve a complaint.

I understand the following:

- I have the right to refuse to sign this authorization; however, if I refuse to sign this authorization, I understand that UDC Dental California, Inc. may not be able to gather the information necessary to determine if I am eligible for coverage or benefits under UDC Dental California, Inc. I understand that a photocopy or facsimile of this authorization is as valid as the original. Upon request, I may receive a copy of this authorization.
- This authorization is voluntary. I may revoke it any time by writing Sun Life Financial, Privacy Office, PO Box 419052, Kansas City, MO 64141-6052. Any such revocation will not affect any actions that Companies took before receipt of the revocation.

Prepaid dental products are provided by UDC Dental California, Inc., which is affiliated with Sun Life Assurance Company of Canada (Wellesley Hills, MA).

UDC Dental California, Inc. 2349 Gateway Oaks Drive, Suite 250 Sacramento, California 95833

Toll Free 800.442.0911 Fax 916.261.3401

- Federal law requires that we inform you that the information we collect may, under certain circumstances, be re-disclosed by us to third parties and thus no longer protected by federal law. Oklahoma only – we are required to inform you that **the information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**
- I understand that any information obtained by this authorization may be used and disclosed by HIPAA and non-HIPAA plans.

- This authorization is effective from the date signed below until _____.
  DATE OR EVENT *(NOT TO EXCEED 24 MONTHS)*

Signature of Insured/Member
or Personal Representative _____ Date _____
(Form MUST be completed before signing.)

Printed name of Personal Representative _____ Phone no. _____

Relationship to insured/member
or nature of authority _____

(If you are the Personal Representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as Personal Representative.)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please mail or fax your Authorization for processing
to the address listed below:

UDC Dental California, Inc.,
2349 Gateway Oaks Drive, Suite 250
Sacramento, CA 95833

Toll Free 800.442.0911
Fax 916.261.3401