rayant℠

Rayant Insurance Company of New York
Rayant Insurance Company of Pennsylvania
Horizon Companies

Authorization for Disclosure of Protected Health Information (Dental Only)

This Authorization is Voluntary

Instructions: To authorize the use and disclosure of your private information (PI) held by Rayant, please complete the information below, sign in the space provided and return to: Rayant-Dental Programs Correspondence Unit, P.O. Box 228, Newark, New Jersey 07101-0820

Member Information (Please Print)

Date: _____ **Member ID:** _____
(ID number on your dental identification card)

Name: _____ **DOB:** _____

Address: _____ **Telephone:** _____

_____

My **protected health information** is information about me, including information such as my name and address and/or dental information. The information was used or created when I received dental care or when payment was received for my dental care. The information may include my past, present or future dental treatment.

I understand that if the persons or organizations I authorize to receive and/or use the protected health information described above are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that my authorizing the use and disclosure of my "protected health information" is not a condition of my enrollment in your dental plan, my eligibility for benefits or payment of my claims.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

I authorize _____ and its affiliates to disclose the above individual's "protected
(Dental Plan/Payer Name)
dental information" to _____

_____
(You must include the name, address and phone number of the person or entity receiving the information)

Description of Information to Be Disclosed: _____
(Attach a separate sheet if necessary) _____

Purpose of Disclosure: _____
(Attach a separate sheet if necessary) _____

Disclosure of Sensitive Information

I understand that the dental plan needs my specific authorization to release my protected health information pertaining to the items listed below. By initialing, I authorize release of the information pertinent to my case.

HIV/AIDS _____ *(Initials)* _____ *Expiration date*

Expiration: This authorization will expire on _____/_____/_____ or on occurrence of the following event:

_____
(The above must relate to the purpose of the use and/or disclosure being authorized.)

Right to Revoke: You may revoke this authorization at any time. Contact the customer service department of your dental plan for further instructions. Your revocation of this authorization will not affect any action we take before we receive your notice of revocation.

Signature: _____ **Date:** _____
(Person Granting Authorization)

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

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