



Member Authorization Form to Release Information

Member Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Member ID Number: _____

I authorize the following protected health information to be disclosed (Please check all applicable boxes):

- My claim information:
All dates of service
The following dates of services
Financial information.
Appeal status or information.
Plan or benefit coverage information.
Dependent(s) claim information (Name the dependant(s)):
All dates of service
The following dates of services
Any other information regarding my account and/or dependent(s).

I authorize Dominion National (hereinafter referred to as "Dominion") to disclose the above protected health information to the following person(s) or organization(s). I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization is not subject to federal health information privacy laws, they may further disclose the protected information and the information may no longer be protected by federal privacy laws.

Name of Person or Organization: _____

Address: _____

Phone Number: _____

This authorization will automatically expire on ___ / ___ / ___.
(Please note that even if a specific date is given this authorization will expire no later than six months after termination of enrollment with Dominion.)
Termination of enrollment with Dominion
Six months after termination of enrollment with Dominion

I, _____, have had full opportunity to read and consider the content of this release. I understand that, by signing this form, I am confirming my authorization that Dominion may use and/or disclose my protected health information to the person or organization named on this form for the purpose described above. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to revoke this authorization at any time. I understand that revocation of this authorization will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and send my revocation to the address below.

Signature: _____ Date: _____

If a person other than the Member signs this form, please complete the following:

Personal Representative's Name: _____

Relationship to the Individual: _____

Please return this completed authorization, or direct any questions regarding the form, to the following individual:
Privacy Officer - Dominion National
P.O. Box 21522, Eagan, MN 55121-0522
Fax: 703.859.7706
PrivacyCoordinator@DominionNational.com

Dominion National is the brand name for the Dominion group of companies. Dental plans are underwritten by Dominion Dental Services, Inc. (DDSI). Dominion Dental Services USA, Inc. (DDSUSA) is a licensed administrator of dental and vision benefits. Vision plans are underwritten by Avalon Insurance Company, and administered by DDSUSA, in DC, DE, MD, PA and VA. Vision plans are underwritten by DDSI in all other states where Dominion National operates.

