# SECURECARE DENTAL

## AUTHORIZATION FOR RELEASE OF INFORMATION

**PATIENT/MEMBER**

Name ______________________________________________
Last First Middle Initial

Date of Birth ______/______/______ Subscriber ID#: ______________

Phone ______________________________________________

Relationship to Subscriber ______________________________

**RELEASE TO**

**I hereby authorize SecureCare Dental to release or disclose information related to my dental benefits/care or that of my minor child, with the stipulation that the released information is kept confidential, to:**

Name and address of individual, agency or organization to which information is to be released:

Name ______________________________________________

Company ______________________________________________

Address ______________________________________________

Phone ______________________________________________

**INFORMATION**

**Describe information to be released:**

Date From ______________________ To ______________________

Information: ______________________________________________

______________________________________________

**Reason for release of Information:**

______________________________________________

______________________________________________

**SIGNATURE**

I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure payment of claims, enrollment or eligibility for benefits. I understand there is potential for re-disclosure of this information, and that SecureCare Dental may not be held responsible for such re-disclosure. I understand that this authorization, except for action already taken, may be revoked by me at any time. Unless revoked, this authorization will remain in force for 90 days from the date below. A photocopy of this authorization is to be accepted with the same authority as this original.

Signature of member/parent/guardian: ______________________________

Printed Name ______________________________ Date: ______________________


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