DENTAL HEALTH PLAN
An Affiliate of Delta Dental of California

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I hereby authorize PMI Dental Health Plan ("PMI")* to use or disclose my protected health information as described below.

1. Protected health information to be used or disclosed:

___ Information necessary to identify me including but not limited to, my name, address, telephone number, social security or other identification number, or other information as listed below:

___ Information relating to the *dental services* provided to me, including but not limited to, date of service, type of service, treatment chart, x-rays, dentist notes or other information as listed below:

____ Information relating to the *eye-care services* provided to me, including but not limited to, date of service, type of service, treatment chart, visual field results, optic nerve imaging results such as HRT II or equivalent, corneal topography results, optometrists/ophthalmologists notes or other information as listed below:

___ Information relating to the payment for the dental or vision services including but not limited to PMI's payment, my payment or co-payment, and total or aggregate payments or other information as listed below:

___ Information relating to my eligibility for benefits, including but not limited to enrollment, contribution or payment of the premium for benefits or other information listed below:

____

____

____

My protected health information will be used/disclosed for the following purpose(s):

____

____

____

____

____

2. PMI Dental Health Plan will make the authorized use or disclosure of my protected health information.

3. PMI is disclosing my protected health information to the following recipient(s):

   Jonathan Hayes (MEA/ILS), Kathryn King (MEA/ILS)

   Rosa Aguayo (Delta Representative)

4. I understand that I have the right to revoke this authorization. I understand that my request to revoke this authorization must be in writing and can be mailed to:

   PMI Dental Health Plan
   Attn: Privacy Contact - Quality Management Department
   PO Box 6023
   Artesia, CA 90702-8023

   I also understand that there is an exception to my right to revoke this authorization if PMI has already taken action on the authorization.

5. I understand that my protected health information may be subject to re-disclosure by the recipient and is no longer protected by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

   This authorization is valid for one (1) year from the date or event listed below:

   ____

6. I understand that PMI will provide me with a copy of this authorization.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, payment, enrollment in the dental program, or eligibility for dental benefits.

Please complete all applicable information.

Member Name: ____

(please print)

Member Identification No.: ____

Street Address: City, State, Zip: ______________________________________

____

____

Phone: ____

Signed** Date: ____

____

**If a personal representative is signing this authorization for the individual, please complete the following information.

Name of Personal Representative: ____________________________________

(please print)

Relationship to Individual: ____

* PMI administers the dental programs for these companies in the following states: Alpha Dental Programs, Inc. in Maryland and Texas; Delta Dental Insurance Company in Florida, Georgia and Washington, D.C.; Delta Dental of New York in New York; Delta Dental of Pennsylvania in Pennsylvania and Delta Care Dental Plan, Inc. in Nevada and Utah. PMI administers vision program in the State of California only.