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Standard Insurance Company

Group Dental and/or Vision Insurance
PO Box 82629 Lincoln NE 68501 800.547.9515 Tel 402.309.2580 Fax

Authorization to Release Health-Related Information

This Authorization complies with the HIPAA Privacy and Security Rule. All areas must be completed.

- I authorize Standard Insurance Company (The Standard) to release my dental and/or vision insurance claim information and/or records, verbally or in writing, to_____ (Recipient) for claim(s) or treatment(s) occurring on the following date(s): _____ for the purpose of ☐ at my request ☐ for the following purpose:

  _____

- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct The Standard to release and disclose my dental and/or vision insurance claim records as described above without restriction.

- I understand that The Standard will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

- I understand that if The Standard releases information pursuant to this authorization, the information may be subject to re-disclosure by the Recipient and no longer protected by the Privacy and Security Rule under the Health Insurance Portability and Accountability Act (HIPAA).

- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date below. A photocopy or facsimile of this authorization shall be as valid as the original.

- I understand that I have the right to refuse to sign this authorization. I further understand that, except to the extent that The Standard has relied upon this authorization to disclose requested records, I have a right to revoke this authorization at any time by sending a written statement to Standard Insurance Company, Attention: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Name of Patient *(please print)*	Date of Birth	Policy No.
Signature of Patient or Patient's Representative	Date	Member's Name
Name of Patient's Representative *(please print)*	Daytime Phone No.	

Relationship to the patient *(including authority for status as patient's representative)*

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