United Concordia

HIPAA Privacy Release Form

The Request for Release of Information is being made for the TDP enrollee (including any dependents) identified below.

Effective date _____ Cancel date

---------- _Sponsor's SSN or DBN

_____ Full name of TDP enrollee whose information is being authorized for release

_____ Relationship to authorizing TDP enrollee (Self, Legal Parent, Custodial Guardian)

Date of birth
_____

---------- Phone

Email address

---------- _Dependent child's full name (optional)

---------- _Dependent child's full name (optional)

_____ Dependent child's full name (optional)

---------- _Dependent child's full name (optional)

Note: unless otherwise revoked, this authorization will expire on the above date, event or circumstance or when the dependent reaches 18 years of age

Persons/organizations authorized to receive the information

Authorized individual's full mailing address

_____ ----------

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I understand that I may revoke this authorization at any time by sending a written notice of my revocation to:

United Concordia Companies, Inc.
TDP Customer Service
PO Box 69450
Harrisburg, PA 17106

I understand that revocation of this authorization will not affect any action UCCI or its subsidiaries, affiliates, business associates, etc. took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, UCCI may not use or disclose my health information for any reason except those described in UCCI's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the above date, event or circumstance. If no expiration is stated, this authorization will remain in effect indefinitely until revoked in writing.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses 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 release UCCI, its affiliated companies, employees, officers and business associates from legal liability for any recipient's use or disclosure of information released by UCCI in reliance on this authorization.

_____ ----------

Authorized signature of member or personal representative

Signature Date: _____

How to allow non-custodial parents to receive information

By completing the information on this form, you are authorizing United Concordia Companies, Inc. to release individual health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or by state law protecting the privacy of health information. This form should be used to allow spouses, non-custodial parents, etc. to receive information for the individuals indicated on this form. Authorization will remain in effect indefinitely, unless the authorization is revoked in writing.

Privacy Act Statement

Authority: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 C.F.R. Part 199.17, TRICARE Program; 45 C.F.R. Parts 160 and 164, HIPAA Privacy and Security Rule; E.O. 9397 (as amended, SSN).

Purpose: To provide office automation tools that assist United Concordia Companies, Inc. (UCCI) personnel in carrying out Active Duty Dental Program (ADDP) mission-related functions.

Routine Uses: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, the DoD “Blanket Routine uses” under 5 U.S.C. 552a(b)(3) apply to this collection. Information from this system may be shared with federal, state, local, or foreign government agencies, and to private business entities, including individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

Disclosure: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays.