



Authorization Form

Insured's name: _____

Dental Select ID number: _____

Describe, in detail, the information you are permitting to be disclosed. _____

The name of person(s), or job title of the person(s), you are authorizing your protected health information to be released to. _____

A description of how the information will be used. You may state "at the request of the individual".

An expiration date or event for the authorization. This time period may not exceed one year.

The insured has the right to revoke this authorization at any time provided that the revocation is in writing, except to the extent that: ACE American Insurance Company or Dental Select has taken action in the reliance thereon; or if the authorization was obtained as a condition of obtaining insurance coverage, there is other law providing the insurer with the right to contest a claim under the policy or the policy itself.

ACE American Insurance Company or Dental Select may not condition treatment, payment, enrollment, or eligibility for benefits on whether or not the insured signs the authorization.

If you are authorizing the release of information to someone other than a health plan, health care provider or health care clearinghouse, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state laws.

If a personal representative of the insured signs this authorization, a description of such representative's authority to act for the individual must also be provided.

Signature

Date