Authorization
Assistance in Claim Administration

To: CPS Dental, Inc.

Subject: Authorization to release health information for claims administration

I, _____ (patient's name) authorize CPS Dental, Inc. to release my personal health information for the purpose of resolving the questions about the payment of the claim shown below:

Date of Service	Description	Provider Name

Please release this information to: _____ (name) _____ (title) _____ (organization).

This authorization expires on _____ . I acknowledge that I have received a written copy of this authorization and I understand that I am not required to sign this authorization as a condition of eligibility in the health plan or payment of benefits. I have read and understand all of the notices set forth below.

_____ _____
Patient's Signature Date

_____
Print Patient's Name

If the individual is making an authorization to release health care information for a minor child or incapacitated spouse, parent or older child, the individual must identify his or her authority to act on behalf of the person.

Important Notices Under HIPAA

I, _____ (patient's name) understand that I may revoke this authorization at any time by providing _____ (name) _____ (title) CPS Dental, Inc., 11 Hanover Square, 8th Floor, New York, NY 10005 with written notice that I am revoking this authorization. I understand, however, that I may not revoke this authorization to the extent that CPS Dental, Inc. has acted in reliance upon this authorization prior to the date I revoke this authorization.

I understand that this written authorization will become a permanent record and will be retained by CPS Dental, Inc. for six years as required by law 45 CFR §§164.508(b)(c) and 530(j). I understand that the federal Health Insurance Portability and Accountability Act (HIPAA) protected information rules do not apply to this record and CPS Dental, Inc. representatives may disclose the information to others who have a business need to know for the purpose of administering the claim in question. CPS Dental, Inc., however, will comply with the medical privacy rules required by other laws.

I acknowledge that I have read and understand these notices.

_____ _____
Patient's Signature Date

_____
Print Patient's Name