DELTA DENTAL

# PLAN SPONSOR DISCLOSURE DESIGNEE FORM
# FOR DETAILED PROTECTED HEALTH INFORMATION

**PLEASE PRINT**

**SECTION A: Plan Sponsor Submitting Designation:**

Group Name: ____________________________________________________Group Number: _____________

Address:________________________________________________________________________________

Telephone:___________________________________E-mail:___________________________________________

**Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (*i.e.*, claims, enrollment, eligibility, etc):**

**Describe the purpose for disclosing this protected health information (required for insured groups):**

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**SECTION B: Designated Employee(s) or Class(es) of Employees (i.e., Group Administrator, HR Rep, Billing, etc)**

Employee Name or Class Title: _______________________________________________________________

Address: ___________________________________________________________________________________

Telephone: ______________________________E-mail: ______________________________________________

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**SECTION C: Other Designated Persons (Agents, Brokers, Subcontractors):**

Entity Name: ___________________________________Person's Name or Title: _____________________________

Address: ___________________________________________________________________________________

Telephone: ______________________________E-mail: ______________________________________________

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***Plan Sponsor (or Plan Sponsor's group health plan) hereby certifies that (1) it has amended its plan documents as required by the HIPAA Privacy Rule (45 C.F.R. § 164.504(f)(2)); (2) the purpose of this request for protected health information ("PHI") is to conduct "plan administration functions" as defined in 45 C.F.R.§ 164.504(a); (3) the PHI requested is the minimum amount of information necessary to accomplish the purpose(s) of the request; and (4) Plan Sponsor (or Plan Sponsor's group health plan) has engaged each person designated in Section C above (if any) in a "Business associate" (or "subcontractor") agreement (as applicable). Plan Sponsor acknowledges that by signing this form, its group health plan takes on significant responsibilities under HIPAA. Plan Sponsor shall promptly notify Delta Dental of Virginia of any change to the above-named individuals' (or entities') authorization to receive PHI and to indemnify Delta Dental of Virginia for any adverse consequences of its failure to provide such notice.***

**SIGNATURE OF PLAN SPONSOR'S AUTHORIZED REPRESENTATIVE**

Signature: _______________________________________________ Date: _____________________________________

Print name: ______________________________________________ Title: _____________________________________

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**RETURN COMPLETED FORM TO:** Delta Dental of Virginia, Attention: Corporate Compliance, 4818 Starkey Road, Roanoke, VA 24018 Telephone: (540) 989-8000, Toll-free: (800) 237-6060, Fax: (540) 491-9710.

**Purpose**: This form is to be completed by the Plan Sponsor's authorized representative (as identified in our records) to permit disclosure of detailed Protected Health Information to specified individuals or entities.