argus dental vision
a premier benefits organization

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Use this form if you want Argus Dental & Vision, Inc. (Argus) to give your personal health information to someone other than you.

Section 1:
Patient Name _____ Date of Birth _____
Address _____ City, State, Zip _____
Phone Number _____

Section 2:
Argus will only disclose the personal health information you want to disclose. Please check only one box below to tell Argus the specific personal health information you want disclosed:

☐ Limited Information (go to Section 3)

☐ Any Information (go to Section 4)

Section 3:
Complete only if you selected "limited information." Check all that apply:

☐ Information about your eligibility

☐ Information about your claims

☐ Information about plan enrollment

☐ Information about premium payments

☐ Other specific information (please write below; for example, payment information)

_____

Section 4:
This authorization will expire one (1) year from the date of signing unless specified below:
Desired Expiration Date _____

Section 5:
Fill in the name and address of the person or organization to whom you want Argus to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:
Organization/Person _____
Address _____ City, State, Zip _____
Phone Number _____ Fax Number _____

Section 6:
I authorize Argus to disclose my personal health information listed above to the person or organization I have named on this form. I understand that my personal health information may be re-disclosed by the person or organization and may no longer be protected by law.

_____ _____
Signature of Patient or Authorized Legal Representative Date

_____ _____
Print Name Relationship to Patient (if not patient)

If you are signing as a personal representative, please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the member signed above.