

# Plan Sponsor Protected Health Information Disclosure Designee Form

This form is to be completed by the plan sponsor for the designation and description of "those employees or classes of employees or other persons under the control of the plan sponsor" to whom Protected Health Information (PHI) may be disclosed.

## Section A: Plan Sponsor Submitting Designation

Group Name	Group Number
Address	
Telephone (    )	Email Address

## 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 (    )	Email Address
Specifically and meaningfully describe the PHI you are authorizing be used and/or disclosed (i.e. claims, enrollment, eligibility, etc.)	

## Section C: Other Designated Persons (Agents, Brokers, Subcontractors)

Entity Name	Person's Name or Title
Address	
Telephone (    )	Email Address
Specifically and meaningfully describe the PHI you are authorizing be used and/or disclosed (i.e. claims, enrollment, eligibility, etc.)	

**Please note:** Delta Dental of Virginia assumes by receipt of this request that it is submitted in compliance with all relevant HIPAA regulations, including, but not limited to, the Minimum Necessary Standard and the Business Associate Contract Standard (with respect to the entity receiving the PHI).

## Signature of Plan Sponsor

Signature	Date
Print Name	Title

**Return completed form to:**  
 Delta Dental of Virginia  
 Attn: Compliance Officer  
 4818 Starkey Road  
 Roanoke, Virginia 24018  
 Phone 540.989.8000 • 800.572.3044  
 Fax 540.774.7574