



**PLAN SPONSOR PROTECTED HEALTH INFORMATION
DISCLOSURE DESIGNEE FORM**

Purpose: 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 may be disclosed.

SECTION A: Plan Sponsor Submitting Designation.

Group Name: _____ Group Number: _____

Address: _____

Telephone: _____ E-mail: _____

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: _____

Specifically and meaningfully describe the protected health information 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: _____ E-mail: _____

Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed (i.e. Claims, Enrollment, Eligibility, etc.): _____

Please note that Delta Dental of Virginia assumes by receipt of this request, that this request 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, Attention: Compliance Officer, 4818 Starkey Road, Roanoke, VA 24018, Telephone: (540) 989-8000, Toll-free: (800) 572-3044.