TruAssure Insurance Company
Authorization for Release of Information

By signing this form in Section F below, I authorize TruAssure Insurance Company to release my individually identified health information as described in Section B to the person or entity named in Section C below. I understand that this authorization is voluntary, that I may obtain a copy of this form and that I may revoke it at any time by submitting my revocation in writing to TruAssure Insurance Company.

Please complete the information in all sections.

SECTION A: INDIVIDUAL INFORMATION

Name of Individual	Date of Birth ___/___/_____

Street Address		
City	State	Zip Code

Telephone Number ( )	I.D. Number

SECTION B: DESCRIPTION OF INFORMATION TO BE RELEASED, INCLUDING DATES

SECTION C: NAME OF PERSON(S) OR ORGANIZATION AUTHORIZED TO RECEIVE INFORMATION

Name

Street Address

City	**State**	**Zip Code**

Telephone Number

( )

I understand that once the information is released to the designated person(s) set forth above, pursuant to this authorization, it may no longer be protected by federal privacy regulations.

SECTION D: DESCRIPTION OF THE PURPOSE OF DISCLOSURE

☐ At the request of the individual or

☐ Other_____

SECTION E: EXPIRATION DATE OR EXPIRATION EVENT

This authorization to release information as set forth herein will expire on:

☐ ___/___/_____ (month/day/year) Initials _____

☐ The expiration of my group dental plan with TruAssure Insurance Company Initials _____

I understand that I have the right to revoke this authorization at any time as detailed in the Privacy Notice of TruAssure Insurance Company. I also understand that my revocation of this authorization will not affect any action that TruAssure Insurance Company has taken, or any information it has already released, based upon this authorization before TruAssure Insurance Company has actually received my request to revoke it.

SECTION F: SIGNATURE OF THE INDIVIDUAL AND DATE

Signature of individual or individual's representative: To complete with a digital signature and send electronically, please download this form with Adobe or another PDF reader.	**Date**

Printed name of individual's personal representative

Relationship to individual, including authority for status or representative

RETURN COMPLETED AUTHORIZATION FORM TO:

Compliance Department
TruAssure Insurance Company
111 Shuman Boulevard
Naperville, IL 60563

Fax: (630) 983-4497
Email: compliance@truassure.com