DELTA DENTAL
AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this form. I also understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed, although it may be subject to other privacy laws. I understand that I may have a copy of this completed form if I request it.

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED FOR IT TO BE VALID.

Individual name: _____ ID Number: _____

Persons/organizations authorized to provide Protected Health Information:

Please click on the drop arrow (right side) to select the correct Delta Dental Member Company:

Persons/organizations authorized to receive Protected Health Information:

_____

_____

Purpose of disclosure (unless the individual who is the subject of the information is the recipient):

_____

_____

Specific description of information to be released:

- ☐ All claims information for all dates.
- ☐ Specific procedure Protected Health Information to be released: _____
- ☐ Specific date related Protected Health Information to be released: _____
- ☐ Other, please describe and include date(s): _____

_____

_____

☐ This authorization is valid only until _____/_____/_____ (DD/MM/YR)

OR

☐ This authorization will expire after one year from signature date.

I understand that I may revoke this authorization at any time by notifying Delta Dental in writing, but a revocation will not have any effect on actions that were taken in reliance on the authorization prior to its revocation.

_____

Signature of individual or individual's personal representative Date
(Form MUST be completed before signing)

Printed name of individual's personal representative: _____

Relationship to the individual: _____

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