

**DELTA DENTAL OF ARIZONA:  
AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my individually identifiable health information described below. I understand that this authorization is voluntary. I 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. I understand that I may obtain a copy of this form.

**Subscriber's Name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

**Dependent's Name:** \_\_\_\_\_

Persons/organizations authorized to provide information: **DELTA DENTAL OF ARIZONA**

Persons/organizations authorized to receive the information

Purpose of disclosure is required by both federal and: State Statute or Regulation (A.R.S. §20-2106(2))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

"at the request of the individual" §164.508(c)(1)(iv)

**Specific description of information to be released:**

- All claims information for all dates
- Specific procedure information to be released \_\_\_\_\_
- Specific date related information to be released \_\_\_\_\_
- Other, please describe and include date(s): \_\_\_\_\_

**Section B: Must be completed for all authorizations**

**The patient or the subscriber's representative must read and initial the following statements:**

1. This authorization is valid only for \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YR)

Initials: \_\_\_\_\_

**OR**

2. I understand that this authorization will expire on my renewal date.

Initials: \_\_\_\_\_

**AND**

3. I understand that I may revoke this authorization at any time by notifying Delta Dental of Arizona in writing, but if I do, it will not have any affect on any actions they took before they received the revocation.

Initials: \_\_\_\_\_

**Signature of subscriber or subscriber's representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Form MUST be completed before signing)*

**Printed name of subscriber's representative:** \_\_\_\_\_

**Relationship to the subscriber/authority to act:** \_\_\_\_\_

***\*\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\*\*THE DISCLOSURE YOU REQUESTED ABOVE WILL NOT OCCUR WITHOUT YOUR SIGNATURE\*\*PLEASE REFER TO DELTA DENTAL'S NOTICE OF INFORMATION PRACTICES FOR ADDITIONAL IMPORTANT INFORMATION***

***\*\*You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.\*\*Delta Dental does not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.***