DELTA DENTAL®

Delta Dental of Arizona

Authorization to Release Protected Health Information

A. INDIVIDUAL WHOSE INFORMATION IS TO BE RELEASED

Member Name (First, Middle & Last)		Date of Birth _____/_____/_____ (MM/DD/YYYY)
Phone	Primary Subscriber Name (if different)	Member ID Number

I, or my authorized representative, authorize Delta Dental of Arizona to release my personal and health information as described in this authorization.

B. TYPE OF INFORMATION DELTA DENTAL OF ARIZONA MAY RELEASE

Check one: ☐ Dental ☐ Vision ☐ Dental & Vision

Check one:

☐ My health information relating to the following treatment or condition:_____

☐ Most recent _____ years of health record(s)

☐ My health records for the following date(s):_____

☐ Entire health record (for dental and/or vision as checked above)

- ☐ Exclude my health information related to drug and/or alcohol abuse
- ☐ Exclude my health information related to HIV/AIDS

☐ Other information to be used or disclosed (describe in detail):_____

C. RECIPIENT OF INFORMATION

Individual/Entity Name	Phone
Street Address	Fax
City , State, Zip	Email

I understand that my protected health information may be subject to re-disclosure by the recipient and is no longer protected by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. PURPOSE OF AUTHORIZATION

Check one:

☐ At my request

☐ Other (explain) _____

E. EXPIRATION DATE OF AUTHORIZATION

Check one: (If I fail to list an expiration date or event below, this authorization will expire 1 year from the date signed.)

☐ Upon termination of my coverage

☐ On the following date: _____

☐ On the following event: _____

F. SIGNATURE OF INDIVIDUAL WHOSE INFORMATION IS TO BE RELEASED

_____ Signature

_____/_____/_____ (MM/DD/YYYY)

If a personal representative is signing this authorization, please complete the Name of Personal Representative and Relationship boxes below, and submit proof of authority with this form. A parent or legal guardian may sign for a minor (under the age of 18).

Name of Personal Representative	Relationship

I understand that this authorization is voluntary, and that Delta Dental of Arizona does not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand I have the right to revoke this authorization. I understand that my request to revoke this authorization must be made in writing, and mailed to the address below.

Return completed form to: Delta Dental of Arizona, Attn: Compliance, 5656 W. Talavi Blvd., Glendale, AZ 85306