DELTA DENTAL®

PROTECTED HEALTH INFORMATION RELEASE FORM
(AUTHORIZATION OF REPRESENTATION)

A photocopy of this authorization shall be considered as effective and valid as the original

Member Name _____ Member ID _____
Member Date of Birth _____

I hereby appoint:

Name: _____
Address: _____
Address 2: _____
City: _____ State____ Zip_____ Phone (____) _____
Relationship: ❑Family ❑Provider (NPI_____) ❑ Other _____

as my representative and authorize this individual to act on my behalf. I authorize and direct Delta Dental to provide this individual any and all information requested, which may include Personal Health Information (PHI), as designated below (*check the appropriate box*):

❑ Eligibility information ❑ Complete claim/authorization history ❑ Other (please describe below)

_____

_____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Please be aware that when the person or organization listed above receives this information, they may be able to share it with others without your permission. If they do so, federal and state privacy law may not protect the information.

Authorized By: _____ _____
(Signature of member, or authorized representative*) (Date form signed)

_____ _____
Please print name of person signing this form (Your telephone number)

*Authority of person filing out this form to act on behalf of member: _____

If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, a **copy of the applicable legal document must be attached**.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Please note: the permission granted to release information will remain valid for one year from the date signed. You may specify a lesser time here Date of expiration: _____. You may also revoke this authorization at any time by contacting Delta Dental's Customer Service Department. If you cancel this permission Delta Dental will be unable to take back any information they may have shared previously.

PO Box 9695
Boston, MA02114-9695
Telephone 617-886-1000
Facsimile 617-886-1199
deltadentalma.com