

## 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 <u>Delta Dental of Arizona</u> to release my personal and health information as described in this authorization.		

B. TYPE OF INFORMATION DELTA DENTAL OF ARIZONA MAY RELEASE
Check one: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dental & Vision
Check one:
<input type="checkbox"/> My health information relating to the following treatment or condition: _____
<input type="checkbox"/> Most recent _____ years of health record(s)
<input type="checkbox"/> My health records for the following date(s): _____
<input type="checkbox"/> Entire health record (for dental and/or vision as checked above)
<input type="checkbox"/> Exclude my health information related to drug and/or alcohol abuse
<input type="checkbox"/> Exclude my health information related to HIV/AIDS
<input type="checkbox"/> 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:
<input type="checkbox"/> At my request
<input type="checkbox"/> 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.)
<input type="checkbox"/> Upon termination of my coverage
<input type="checkbox"/> On the following date: _____
<input type="checkbox"/> 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.	
<b>Return completed form to:</b> Delta Dental of Arizona, Attn: Compliance, 5656 W. Talavi Blvd., Glendale, AZ 85306	