



**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing this form, I hereby authorize Delta Dental to use or disclose my protected health information as described below.

1. Protected health information to be used or disclosed:

- Information necessary to identify me including but not limited to, my name, address, telephone number, social security or other identification number, or other information as listed below:
- Information relating to the dental services provided to me, including but not limited to, date of service, type of service, treatment chart, X-rays, dentist notes or other information as listed below:
- Information relating to the payment for dental services including but not limited to Delta Dental’s payment, my payment or co-payment, and total or aggregate payments or other information as listed below:
- Information relating to my eligibility for benefits, including but not limited to enrollment, contribution or payment of the premium for the dental benefit or other information listed below:

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2. My protected health information will be used/disclosed for the following purpose(s):

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3. \_\_\_\_\_ *[Enter job classification or title]*  
will make the authorized use or disclosure of my protected health information.

4. Delta Dental is disclosing my protected health information to the following recipient(s) *[List name(s) and title(s) of recipient(s)]*:

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5. I understand that I have the right to revoke this authorization. I understand that my request to revoke this authorization must be in writing and can be mailed to:

Delta Dental  
Attn: Privacy Officer  
One Delta Drive  
Mechanicsburg, PA 17055

I also understand that if Delta Dental has already taken action on this authorization it cannot be revoked.

6. 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).

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, payment, enrollment in the dental program, or eligibility for dental benefits.

This authorization is valid for one (1) year from the date or event listed below:

\_\_\_\_\_ *[Enter date or event]*

I understand that Delta Dental will provide me with a copy of this authorization.

**PLEASE COMPLETE THE FOLLOWING INFORMATION:**

**NAME: (please print):** \_\_\_\_\_

**IDENTIFIER (SSN):** \_\_\_\_\_

**STREET ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_

**ZIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**SIGNED\*:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**\*If a personal representative is signing this authorization for the named individual, please complete the following.**

\_\_\_\_\_  
**NAME OF PERSONAL REPRESENTATIVE (please print)**

\_\_\_\_\_  
**RELATIONSHIP TO INDIVIDUAL**