DELTA DENTAL®

Authorization for use or disclosure of health information

Complete all sections, date and sign.

I, _____, hereby voluntarily authorize
(Enrollee name)

the disclosure of protected health information as described below:

The information is to be disclosed by:	**For the following recipient:**
Delta Dental of California **Federal Government Programs** **P.O. Box 537015** **Sacramento, CA 95853-7015**	Name of person authorized to receive the disclosed information
	Street address
	City/State

Protected health information (PHI) to be used or disclosed: (check appropriate box(es)

- ☐ Information necessary to identify me including but not limited to my name, address, telephone number, Social Security or other identification number or other health 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, dentists' notes, electronic documents available on the website or other information as listed below
- ☐ Information relating to the payment for the dental services including but not limited to Delta Dental's payment, my payment or copayment and total or aggregate payment 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

_____

_____

_____

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

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 of California
Federal Government Programs
P.O. Box 537015
Sacramento, CA 95853-7015

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).

Policyholder name	Social Security number or Alternate ID
Street address	
City/State	
Signature of person authorizing release	Date

This authorization is valid until termination of enrollment. Please complete all applicable information.

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