HIPAA AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name (print):	Telephone Number:
Previous Names (if applicable):	Date of Birth:

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. Release information to:

Name (individual, organization or "personal representative"):	Telephone Number:
Address:	Fax Number:

Information to be released from or used by:

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983
Tel: (206)522-1300 or (800)554-1907
Fax: (800)691-4960

Purpose of use or disclosure:	Information to be used or disclosed:	
☐ Specialty Care	☐ Information as needed to personal representative authorized by patient	
☐ Self	☐ Claim records from previous year	☐ Complete designated record set
☐ Other	☐ Summary coverage information	☐ Other

Dates of Service/Treatment:

Signature of patient or representative:	Relationship to patient:	Date:

Authorization expiration date (six month standard unless otherwise noted):

If the patient is unable to sign, please indicate such and your authority to act for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions on how to revoke this authorization. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected.

Please note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.

For Delta Dental of Washington Use:		
Date Received: _____	Date Information Released:_____	Sub #_____
PHI disclosed via: Mail o Fax o	Phone o Picked up by requestor o	Delivered by patient o