AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____, hereby voluntarily authorize the disclosure of protected health information as described below:
(Enrollee Name)

The information is to be disclosed by:	**And is to be provided to the following recipient:**
Delta Dental of California	NAME OF PERSON AUTHORIZED TO RECEIVE THE DISCLOSED INFORMATION
P. O. Box 997330	STREET ADDRESS
Sacramento, CA 95899-7330	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 or other information as listed below

☐ Information relating to the payment for the dental services including but not limited to Delta's payment, my payment or co-payment 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 Plan of California
Attn: Subscriber Services Department
P. O. Box 7736
San Francisco, CA 94120

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). Delta will not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

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

Please complete all applicable information.

ENROLLEE NAME	SOCIAL SECURITY NUMBER
STREET ADDRESS	
CITY/STATE	
SIGNATURE	DATE