AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

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

The information is to be disclosed by:	And is to be provided to the following recipient:
Delta Dental of California and Affiliates	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 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 and Affiliates
Attn: Subscriber Services Department
P. O. Box 997330
Sacramento, CA 95899-7330

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).

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

Please complete all applicable information.

POLICYHOLDER NAME	SOCIAL SECURITY NUMBER OR ENROLLEE ID
STREET ADDRESS	
CITY/STATE	
SIGNATURE OF PERSON AUTHORIZING RELEASE	DATE

AFFILIATE LIST ON PAGE 2

Delta Dental of California and its Affiliates

- Delta Dental of California
- Delta Dental Insurance Company
- Delta Dental of Delaware
- Delta Dental of New York
- Delta Dental of Pennsylvania
- Delta Dental of the District of Columbia
- Delta Dental of Puerto Rico
- Delta Dental of West Virginia
- Alpha Dental of Alabama, Inc.
- Alpha Dental of Arizona, Inc.
- Alpha Dental of Nevada, Inc.
- Alpha Dental of New Mexico, Inc.
- Alpha Dental of Utah, Inc.
- Alpha Dental Programs, Inc. (TX)
- Dentegra Insurance Company
- Dentegra Insurance Company of New England
- Delta Reinsurance Corporation