Designation of Representative /Authorization Form

This form is to be filled out by a member if there is a request to release the member's health information to another person or company or a request to appoint an Authorized Representative. Please include as much information as you can.

PART A: MEMBER INFORMATION			
Member last name	Member first name	Middle Initial	Member date of birth
Member street address	City	State	ZIP code

Daytime phone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO CAN RECEIVE MY INFORMATION	
The following people or companies have the right to receive my information. They must be 18 years of age or older. Please check each box that applies and enter first and last name.	
☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under title XViii of the Social Security act (the "act") and related provisions of title Xi of the act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

PART D: PERSON OR COMPANY WHO CAN ACT AS MY AUTHORIZED REPRESENTATIVE

The following person or company has the right to act as my Authorized Representative. An Authorized Representative is a person who you appoint to be your representative in carrying out a grievance or appeal, including any external review rights that may be available to you. They must be 18 years of age or older. Please also complete Part B and C above to authorize the release of your information to your Authorized Representative.

Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 – enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end:

☐ At the conclusion of the appeals process.

☐ One year from the signature date in Part G.

☐ Upon the date, event or condition described below (please provide details):

PART F: PURPOSE OF THIS APPROVAL

☐To allow an individual to act as my Authorized Representative in carrying out a grievance or appeal, including any external review rights that may be available to me.

☐ To disclose information at my request.

PART G: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Delta Dental to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Delta Dental does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Delta Dental. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN	
If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following: • A copy of a health care, general or Durable Power of Attorney; OR • A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf. Please complete the following:	
Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code
Signature **X**		Date	

Please return the completed form to:

Delta Dental
Appeals and Grievances Dept
PO Box 1860
Alpharetta, GA 30023-1830

Be sure to keep a copy of this form for your records.