Protected health information disclosure authorization

Delta Dental of Oregon & Alaska

When completed, this form signifies member authorization allowing the disclosure of protected health information to another person/entity. To expedite your authorization, please print legibly in black or blue ink and return as instructed.

Section 1: Member (Patient) Information

Name	Date of birth (mm/dd/yyyy)	ID no.
Employer name		Group no.

Section 2: Authorization

I understand that in connection with the provision of member services to me, Delta Dental has certain protected health information pertaining to me. I authorize Delta Dental of AK and OR to use and disclose a copy of my protected health information to:

Name		Relationship	
Address	City	State	ZIP

For the purpose of (select one):

☐ Discussing all information related to my health coverage, treatment and payment.

☐ Other (please specify purpose): _____

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. I understand and agree that such information will be disclosed if I check the box next to the type of information to be included with the disclosure:

☐ HIV/AIDS test or result information and related records

☐ Drug/alcohol diagnosis, treatment, or referral information

☐ Reproductive health

☐ Genetic testing information

☐ Mental health information

I understand that I have the right to refuse to sign this authorization. My refusal to sign this authorization will not affect my enrollment in a health plan or eligibility for health benefits.

I have the right to revoke this authorization in writing at any time. If I revoke this authorization, the information described above will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back.

To revoke this authorization, please send a written statement to: Delta Dental, Privacy Office at 601 S.W. Second Ave., Portland, OR 97204 and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

Unless revoked, this authorization shall be in force and effect until the following (select one):

☐ Date: _____ / _____ / _____ (not to exceed 24 months from the date of signature)*

☐ Event: _____
(The event will be limited to 24 months maximum. Listing an event such as "Death," "Termination of Policy" or "Until Revoked" are examples of invalid events which will result in the return of this authorization as invalid).

**If a date is not submitted (left blank), the authorization will be limited to 24 months from the date of signature.*

By signing below, I agree that I have reviewed and I understand this authorization

Signature of individual X	Signature date

or

Signature of individual's representative X	Signature date
Print name of representative	Relationship**

***Please attach legal documentation if you are the legal guardian, legal custodian or holder of Power of Attorney or have other legal authority for the member.*

All fields must be completed for this authorization to be valid. Member should retain a copy of the completed form.

Ready to submit? Mail this form to Delta Dental:
Delta Dental Privacy Office
601 SW Second Ave., Portland, OR 97204

Questions? Contact Delta Dental Customer Service at 833-212-5036 (TTY users, dial 711), or email DDORMedicare@DeltaDentalOR.com.

DeltaDentalAK.com | DeltaDentalOR.com

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