

**DELTA DENTAL OF ARIZONA:
AUTHORIZATION FOR RELEASE OF INFORMATION**

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information described below. I understand that this authorization is voluntary. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that I may obtain a copy of this form.

Subscriber's name: _____ **ID Number:** _____

Dependent's Name: _____

Persons/organizations authorized to provide information: **DELTA DENTAL OF ARIZONA**

Persons/organizations authorized to receive the information:

Purpose of disclosure is required by both federal and State Statute or Regulation (A.R.S. §20-2106(2)):

"at the request of the individual" §164.508(c)(1)(iv)

Specific description of information to be released:

- All claims information for all dates.
- Specific procedure information to be released _____
- Specific date related information to be released _____
- Other, please describe and include date(s):

Section B: Must be completed for all authorizations

The patient or the subscriber's representative must read and initial the following statements:

1. This authorization is valid only for ___/___/___ (DD/MM/YR) Initials: _____

OR
2. I understand that this authorization will expire on my employer group renewal date. Initials: _____

AND
3. I understand that I may revoke this authorization at any time by notifying Delta Dental of Arizona in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Initials: _____

Signature of subscriber or subscriber's representative
(Form *MUST* be completed before signing)

Date

Printed name of subscriber's representative: _____

Relationship to the subscriber/authority to act: _____

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**THE DISCLOSURE YOU REQUESTED ABOVE WILL NOT OCCUR WITHOUT YOUR SIGNATURE**PLEASE REFER TO DELTA DENTAL'S NOTICE OF INFORMATION PRACTICES FOR ADDITIONAL IMPORTANT INFORMATION** You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.**The Delta Dental does not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs th is authorization.***