DELTA DENTAL®

Authorization for Release of Health and Payment Information

This signed form authorizes Delta Dental of New Jersey, Inc., Delta Dental of Connecticut, Inc., or Flagship Dental Plans to disclose specified protected health information about the person named below in **Section 1** to the authorized person named in **Section 2**.

Section 1: Person whose information will be disclosed:

Name:	Date of birth:

Name of member under whose plan you have dental benefits (if different than the person whose information will be disclosed):

Delta Dental member ID #:	Delta Dental group name:	Delta Dental group number:

Section 2: Authorized person receiving health or payment information:

Name:	Phone number:

Address:

Section 3: Protected health information I authorize Delta Dental to disclose:

Information/Documentation	**Disclose Yes or No**	**Fill in dates of service From:**	**To:**
Claim information	☐ Yes ☐ No		
Payment information	☐ Yes ☐ No		
Treatment records of my provider (if available)	☐ Yes ☐ No		
Diagnostic records of my provider (if available)	☐ Yes ☐ No		
Financial records of my provider (if available)	☐ Yes ☐ No		
Enrollment information	☐ Yes ☐ No		
Other (please describe)	☐ Yes ☐ No		
All the above	☐ Yes ☐ No		

1. I understand that the disclosed information may include information relating to:
   - Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
   - Treatment for drug or alcohol abuse
   - Mental or behavioral health or psychiatric care
   - Pregnancy

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2. Reason for release of information:

   Please provide the reason why you are asking Delta Dental to release the protected health information. If you do not wish to state a purpose, please write, "At the request of the individual."

3. Right to revoke:

   I understand that I have the right to revoke this authorization at any time by notifying Delta Dental in writing at 1639 Route 10, Parsippany, NJ 07054, Attention: Compliance Manager. I understand that the revocation only takes effect after it is received and processed by Delta Dental and that it will not affect any use or disclosure made before revocation of this authorization.

4. I understand that after the information is disclosed, federal law might not protect it, and the person who receives the protected health information might redisclose it.

5. I understand that Delta Dental may not restrict treatment, payment, enrollment, or eligibility for benefits based on this signed form.

6. I understand that I am entitled to receive a copy of this authorization from the person who requested I sign this form.

7. I would like this authorization to expire on _____ (date) unless I revoke the authorization in writing before this date.

_____ _____

Signature of person from **Section 1** whose information will be disclosed | Date

If the person signing this form is not the person whose information is being disclosed or is not of legal age to provide the authorized release, please acknowledge and sign below:

☐ I have the legal authority to request disclosure of the protected health information for the person named on this form. Signers may be asked to present legal documentation such as a Power of Attorney to act on the behalf of the person whose protected health information will be disclosed.

_____ _____

Signature of legally authorized representative | Date

_____ _____

Printed name of representative | Relationship to person from Section 1

Once completed, please return to Delta Dental:

Mail:
Delta Dental of New Jersey
PO Box 16354
Little Rock, AR 72231

Fax:
973-944-4543

Questions?
Please call Customer Service at **800-452-9310**
Monday - Thursday: 8:00 a.m. to 6:30 p.m. ET
Friday: 8:00 a.m. to 5:00 p.m. ET