DELTA DENTAL OF NEW JERSEY, INC.
DELTA DENTAL OF CONNECTICUT, INC.,
FLAGSHIP DENTAL PLANS
AUTHORIZATION FOR RELEASE OF HEALTH AND PAYMENT INFORMATION

Authorization Form for Disclosure of Protected Health Information to Third Parties

This form, if signed, will authorize Delta Dental of New Jersey, Inc., Delta Dental of Connecticut, Inc., and/or Flagship Dental Plans, as applicable or as specified (together referred to as "Delta Dental" New Jersey System) to disclose specified health information about the person named in Item 1 below.

1. I hereby authorize the disclosure of health and payment information relating to:

Patient Name: ______________________
Date of Birth: ______________________
Member ID Number: ______________________
Group Number: ______________________

2. I hereby authorize you to release this information to:

Name: ______________________
Address: ______________________
____

3. The information I authorize you to disclose (referred to as the "Information") consists of:

Indicate Yes or No	Information/Documentation	Provide the Date(s) of Service From / To
______	Claim Information	______ / ______
______	Payment Information	______ / ______
______	Treatment Records of My Provider	______ / ______
______	Diagnostic Records of My Provider	______ / ______
______	Financial Records of My Provider	______ / ______
______	Enrollment Information	______ / ______
______	Change of Primary Care Facility	______ / ______
______	Other (Describe);	______ / ______
______	______________________	______ / ______
______	All of the above	______ / ______

4. I understand that the disclosed Information may include information relating to:

- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- Treatment for drug or alcohol abuse

- Mental or behavioral health or psychiatric care
- Pregnancy

5. Purpose of the request:

(Please state why you are authorizing the person(s) named in Item 2 to receive the Information. If you do not wish to state a purpose, please state, "At the request of the individual.")

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6. Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying Delta Dental New Jersey System in writing at 1639 Route 10, Parsippany, New Jersey 07054, Attention Compliance Manager. I understand that the revocation is only effective after it is received and logged by Delta Dental New Jersey System. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

7. I understand that after the Information is disclosed, federal law might not protect it and the recipient might redisclose it.

8. I understand that the Delta Dental New Jersey System may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

9. I understand that I am entitled to receive a copy of this authorization.

10. Unless otherwise revoked, this authorization will expire on the earlier of ___________ (date) or the termination of my dental coverage administered by Delta Dental New Jersey System.

11. If a Personal Representative executes this form, that Representative hereby warrants that he or she has authority to sign this form on the basis of: ____________________________________

____
Signature of individual or individual's legally authorized representative
(Signers other than the individual or his natural parent must present legal documentation such as a power of attorney that authorizes them to act on the individual's behalf).

Date: ______________

____
Printed name of patient's representative

____
Relationship to patient giving representative authority to act for patient