DELTA DENTAL OF NEW JERSEY, INC.
DELTA DENTAL OF CONNECTICUT,
INC. ("DDCT") 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. and its affiliate, Flagship Dental Plans and Delta Dental of Connecticut, Inc. (for which Delta Dental administers claims for contracts DDCT writes in Connecticut) (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