DELTA DENTAL®

Delta Dental of Rhode Island
Authorization to Release Protected Health Information ("PHI")

In accordance with federal privacy laws, this authorization must be completed by the subscriber, covered spouse or covered dependent child over age 18 when requesting PHI to be disclosed to a person or entity other than to another covered dependent in a family plan.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION. WE WILL NOT CONDITION YOUR ENROLLMENT IN OUR PLAN OR YOUR ELIGIBILITY FOR BENEFITS ON YOUR SIGNATURE.

I. Member Information

1. Name of Member whose information is to be released: _____

2. Member (in #1) Date of Birth: _____

3. Subscriber ID Number: _____

4. Name of Subscriber: _____

II. Please read and/or complete the following statements carefully

5. By signing this form, you authorize Delta Dental to disclose protected health information ("PHI") related to the processing of dental claims to the persons specified in #6 below. The PHI you are authorizing Delta Dental to disclose is:

☐ The entire record set associated with services specified in claim number _____ with the following exceptions (if any): _____ ;

or

☐ Specific description of information being disclosed (including date(s)): _____

_____

_____

_____ .

6. Delta Dental may disclose the PHI to the following persons who may be assisting in the resolution of your concerns[1]:

Name of person: _____

Daytime telephone number: _____

_____

[1] Please note that, to the extent these persons, classes of persons, or organizations are not health plans, covered health care providers, or health care clearinghouses subject to the federal Privacy Rule, they may further disclose the PHI, and it may no longer be protected by the Privacy Rule.

III. Expiration and Revocation (Cancellation).

7. Expiration: This authorization will expire (check one)

☐ Upon the resolution of the claims issue or other concern identified to Delta Dental in #5 above; or

☐ On _____/_____/_____.
(MM) (DD) (YYYY)

8. I understand that I may cancel this authorization at any time by writing to the address listed below. However, I understand that the written cancellation will not affect authorized uses and disclosures made prior to receipt of the written cancellation.

Delta Dental of Rhode Island
10 Charles Street
Providence, RI 02904
Attn: Customer Service

9. Signature: _____ **Date:** _____
(of individual authorizing release of information)

Print Name: _____
(of individual authorizing release of information)

10. If this Authorization is signed in #9 above by a parent of a minor child under age 18 or other *Personal Representative*[2] on behalf of the individual, please complete the following:

Parent/ Personal Representative's Name: _____

Relationship to Individual or description of *Personal Representative's* authority to act on behalf of the Member (see footnote below): _____
(For other than a parent, attach documentation of the representative's authority to act on behalf of the member.)

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE ADDRESS LISTED ABOVE OR FAX TO (401) 752-6040.

[2] A *personal representative* is defined as a person authorized (under State or other applicable law) to act on behalf of the individual in making health care related decisions, or to act on behalf of a decedent or the estate (not restricted to health care decisions). Examples include a parent with respect to a minor child under the age of 18, a legal guardian of a mentally incompetent adult, the executor of an estate, or an individual with a health care power of attorney.