DELTA DENTAL®

Authorization Form for the Use and /or Disclosure of Protected Health Information

I authorize Delta Dental of Massachusetts to use and/or disclose my protected health information as described below. Please provide the following information in order for us to comply with this request.

1. I authorize the disclosure of my protected health information to the following persons for the described purposes only:

   _____

   1. Name Address

   _____

   Purpose for obtaining this information

   _____

   2. Name Address

   _____

   Purpose for obtaining this information

2. This authorization expires upon (insert date or event): _____

3. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations then such information may be re-disclosed by that person or entity and would no longer be protected.

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

5. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal regulations found under 45 C.F.R. 164.524).

6. Please sign this form and provide the required information below so that we may comply with your request. Completion of this form will not in any way affect your eligibility for benefits.

7. I certify that I have received a copy of this authorization.

_____

Signature Date

_____

Name Patient's Delta Dental ID #

_____

Name of Personal Representative Relationship to the Patient