Delta Dental of Wisconsin
Personal Representative Form

Note: This form is used to confirm an enrollee's permission that Delta Dental of Wisconsin may discuss or disclose his/her protected health information to a particular person who acts as his/her Personal Representative. Use of their information is strictly limited to that purpose described above.

Section A: Enrollee Information

By signing this form in Section E below, I understand and agree that Delta Dental of Wisconsin may release my personal health information as defined in Section B below to my Personal Representative(s) named in Section C below.

Enrollee Name: _____

Address: _____

Telephone Number: _____ Enrollee ID Number: _____

E-mail Address: _____

Section B: Type of Information to be Shared

_____

_____

_____

Section C: Authorized Use and/or Disclosure

Intended Use or Disclosure:
I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Personal Representative #1:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

Personal Representative #2:

Name: _____ **Phone Number:** _____

Address: _____

Relationship to You: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Personal Representative's access to information about a particular health care provider or a particular dental record. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Limitations on Disclosure:

_____

_____

Section D: Expiration and Revocation

This authorization to release information to my Personal Representative will automatically expire two years following the termination of my health plan enrollment.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Personal Representative, I must revoke this authorization **in writing** by giving written notice of my decision to the contact person named below. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Contact: Privacy Official, Delta Dental of Wisconsin
Address: P.O. Box 828, Stevens Point, Wisconsin, 54481
Or FAX to: 1-888-899-4030

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Personal Representative Form. I confirm that this authorization is consistent with my request of Delta Dental of Wisconsin. I understand that, by signing this form, I am confirming my authorization that Delta Dental of Wisconsin may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature: _____ Date: _____

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED IN SECTION D.
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.