Appendix A-1
Authorization to Release Health Information

DELTA DENTAL OF WISCONSIN, INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed, although it may be subject to other privacy laws. I understand that I may have a copy of this completed form if I request it. I am not required to sign this form to receive my dental benefits (enrollment, treatment or payment).

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED FOR IT TO BE VALID.

Individual name:_____ ID Number:_____

Persons/organizations authorized to provide information: DELTA DENTAL OF WISCONSIN, INC.

Persons/organizations authorized to receive disclosure:

_____

_____

Purpose of Disclosure (unless the individual who is the subject of the information is the recipient):

_____

_____

Specific description of information to be released:

☐ All claims information for all dates.
☐ Specific procedure information to be released: _____
☐ Specific date related information to be released: _____
☐ Other, please describe and include date(s): _____

_____

_____

_____

_____ This authorization is valid only until __/__/____ (DD/MM/YR)

OR

_____ This authorization will expire on my employer group renewal date.

I understand that I may revoke this authorization at any time by notifying Delta Dental of Wisconsin, Inc. in writing, but if I do it will not have any affect on any actions they took before they received the revocation.

_____ _____

Signature of individual or individual's personal representative **Date**
(*Form MUST by completed before signing*)

Printed name of individual's personal representative:_____
Relationship to the individual:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.