DELTA DENTAL®

Release of Information

Attached is the Release of Information Authorization Form you recently requested from Delta Dental of Colorado.

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse), must first be authorized. Authorization includes the signature of the individual authorizing the release of their information.

Effective April 14, 2003, information will not be available to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent. (An authorization is not required for Delta Dental to release information to your treating dentist.)

The purpose of the enclosed form is to allow your dependent who is 18 years or older, or your spouse, to authorize the release of dental claims history, benefit information, etc. to a parent or spouse if he or she so desires.

All information on the Release of Information Authorization Form is required in order for Delta Dental to process your request.

Please contact Customer Relations at 1-800-610-0201 with any additional questions. Return the completed form to:

Delta Dental of Colorado
Attention Customer Relations
P.O. Box 173803
Denver, CO 80217-3803
FAX: 303-741-2116.

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Release of Information Authorization Form

All information must be completed for Delta Dental to process this Release of Information request.

Subscriber Information

Subscribers First Name:

Subscribers Last Name:

Member ID number or SSN of Subscriber:

Information Regarding Person Authorizing Releasing his/her Information

First Name of Person Authorizing Release:

Last Name of Person Authorizing Release:

Member ID Number or SSN of Person Authorizing Release:

The following is an authorization allowing Delta Dental of Colorado to release information to whomever you designate. Delta Dental of Colorado is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that Delta Dental of Colorado may release information to:

Address of person/organization that Delta Dental of Colorado may release information to:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing (and present my written revocation) to Delta Dental of Colorado. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that information used or disclosed under this authorization may be subject to re-disclosure and no longer protected by the HIPAA Privacy Rule.

This authorization will expire one year from the date of your signature. If you wish to grant authorization for less than one year, please indicate expiration date:

Signature of individual authorizing the release of information

Date

If signing on behalf of another, please describe one's authority to act for the individual (power of attorney, legal guardian, etc).