DELTA DENTAL®

Individual Authorization Form

This form authorizes Delta Dental of Virginia, or a third party administrator acting on its behalf, to use and/or disclose protected health information (PHI), or to receive PHI from another entity.

SECTION A: The individual confirming the authorization of the use and/or disclosure of PHI. I authorize the use and/or disclosure of my PHI as described in Section C. I understand this authorization is voluntary.

Name		Email
Address (include city, state and zip)		
Phone	Subscriber ID Number	Last four of Social Security Number

I authorize Delta Dental of Virginia and/or its representative to use or disclose the following information on my behalf (check only one box):

☐ All of my information including diagnosis, claims and provider and financial information such as claims may be disclosed, ***OR***

☐ Only the information checked below may be disclosed:

☐ Appeal	☐ Provider	☐ Financial
☐ Benefits and coverage	☐ Pre-determinations	☐ Vision
☐ Billing	☐ Pre-authorizations	☐ Pharmacy
☐ Claims and payment	☐ Referral	☐ Eligibility and enrollment
☐ Diagnosis and procedure	☐ Treatment	☐ Dental

☐ Medical records (excludes psychotherapy notes)

☐ Other_____

I also authorize the following types of sensitive information checked below:

☐ Alcohol/substance abuse records ☐ Maternity records ☐ Mental health

☐ Other _____

The purpose of this authorization is:

☐ To generally allow for the disclosure of information at my request.

☐ Other _____

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Individual Authorization Form (continued)

SECTION B: Individual/entity authorized to receive PHI	
Name of representative	
Mailing address (include city, state and zip)	
Phone	Email
Relationship to the enrollee (e.g., attorney, relative, friend)	

SECTION C: Description of protected health information

I authorize Delta Dental of Virginia or its agent/representative to disclose and/or to use any PHI (except psychotherapy notes) the above-named individual/entity may request. This information may include information pertaining to chronic diseases, behavioral health conditions, communicable diseases including HIV or AIDS and/or genetic information, if applicable.

_____ By initialing here, this authorization includes alcohol and substance abuse records, if applicable

SECTION D: Expiration and revocation — unless previously revoked, this authorization will terminate on the earliest of the following dates:

☐ The date coverage ends ☐ One year from the signature date below

☐ Upon the following date, event or condition (i.e. child reaches age of maturity, lawsuit has been settled, divorce is finalized, etc.). _____

Right to revoke: I understand I may revoke this authorization at any time by sending written notice of my revocation to the address shown below. I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation. I also understand that you may continue to make HIPAA-compliant disclosures that do not require specific authorization (i.e. payment, treatment and operational purposes).

I have read the contents of this authorization, and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and Delta Dental cannot condition my treatment, payment, enrollment or eligibility for benefits on this authorization. Delta Dental or a third party administrator acting on its behalf, may use and/or disclose to the persons and/or organizations named herein, the PHI described in this form. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature_____ Date _____

Authorized Representative Signature_____ Date_____

Authority to act on the individual's behalf (choose one): if signed by an authorized representative, a copy of a Power of Attorney, court order or other document establishing custody or legal documentation demonstrating the authority of the authorized representative to act on the individual's behalf must be attached.

☐ Patient ☐ Custodial parent ☐ Power of Attorney ☐ Other _____

Return completed form to: Delta Dental of Virginia, Attention: Benefit Services, 5415 Airport Road, Roanoke, VA 24012. Phone: 540.989.8000, or toll-free: 800.237.6060. Fax: 540.491.9714.

You and your authorized representative are entitled to a copy of the signed authorization form.