



Delta Dental Plan of Colorado

PO Box 173803
Denver, Colorado 80217-3803
fax 303-741-2116

Release of Information Authorization Form

To Whom It May Concern:

Attached please find the Release of Information Authorization you recently requested from Delta Dental Plan of Colorado.

In compliance with federal and state law, the release of information for any dependent 18 years or older, or the information released from one spouse to another, must first be authorized. Authorization must include the signature of the individual authorizing the release of 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 aged 18 or older) without first having this Release of Information Authorization on file. For example: if the insured person calls regarding the claim status for a claim on a 19 year old dependent, that information will not be given to the insured without the written consent of the dependent. The same situation holds true for spouse to spouse information. Parents do have a right to information on children under the age of 18 without the child's written consent. (An authorization is not required for Delta to release information to your treating dental provider.)

The purpose of the enclosed form is to enable your dependent who is 18 years of age or older, or 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 Authorization indicated with an asterisk (*) is required in order for Delta to process your request. The information required on the top section of the Authorization is required for Delta to locate the member(s) in our system. There are also two pieces of information required in the center section of the form, to indicate whom Delta may release information to.

Please feel free to contact Customer Relations with any additional questions. This form, once completed, may be returned to Delta Dental Plan of Colorado, attention: **Customer Relations, PO Box 173803, Denver, Colorado 80217-3803, or fax 303-741-2116.**

Sincerely,

The Customer Relations Department

* Date: _____

Subscriber Information:

* First/Last Name of Subscriber: _____

* Social Security Number of Subscriber: _____

Information regarding person authorizing releasing his/her information:

* First/Last Name of person authorizing release: _____

* Date of Birth of person authorizing release: _____

* Social Security Number of person authorizing release: _____

The following is an authorization allowing Delta Dental Plan of Colorado to release information to whomever you designate.

Delta Dental Plan of Colorado is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, provider information, and enrollment information, unless otherwise specified.

The information identified above may be given to the following individual(s) or organization(s):

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

* Address of person/organization that Delta Dental Plan 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 Plan 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.

Unless I specify differently, this authorization will expire one year from the date above. If I fail to specify an expiration date or event, this authorization will expire twelve months from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary.

* _____

Signature of individual authorizing the release of information

* _____

Date

✓ All Information indicated above as required (*) must be completed for Delta Dental Plan of Colorado to process this Release of Information request.