DELTA DENTAL®

Delta Dental of South Dakota **Authorization for Release of Health Information**

Please complete all fields with bold headings.

I, _____ **(Print Legal Name)**, hereby authorize the use and disclosure of my health information by Delta Dental of South Dakota as described in this authorization.

Subscriber ID#: _____**Date of Birth:** _____ **Phone number**: _____

Type of information Delta Dental of South Dakota may release (please check items below and indicate dates, when applicable):

- ☐ Verbal information only *Specify:*_____
- ☐ Claims information (e.g., amount billed, procedures, claims payment/denial, etc.) for dates: _____to_____
- ☐ Premium information (e.g., premium payments, billing cycles, bank drafts, etc.) for dates: _____ to _____
- ☐ Information related to services from _____(*provider name*) for dates: _____to _____
- ☐ All information (e.g., demographic, claims, premium, services, etc.) for dates: _____to_____
- ☐ Other (include dates) _____

Release information to:

Individual/Entity Name: _____ **Phone:** _____

How would you like the information sent: ☐ Mail ☐ Fax ☐ Email

Street Address: _____

City: _____ **State:** _____**Zip:** _____**Fax:** _____

Email (if requesting electronic copy): _____

Purpose of Authorization:

☐ At request of Individual ☐ Continuing Care ☐ Legal ☐ Other: _____

Authorization Expiration Date (if no expiration date/event is selected, this authorization will expire one (1) year from the date signed below)**:**

☐ Upon termination of coverage ☐ On date: _____ ☐ On the following event: _____

I understand that I have a right to revoke this authorization at any time by notifying in writing, *Attn: Privacy Officer, Delta Dental of South Dakota, 720 N Euclid, P.O. Box 1157, Pierre, SD 57501*. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I am not required to sign this form in order to guarantee treatment, payment, eligibility, enrollment or other benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any release of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my information, I can contact Delta Dental of South Dakota's Privacy Officer at 1-800-627-3961.

I authorize the release of information as specified above. I release Delta Dental of South Dakota from all legal responsibility or liability, which may arise from the release of this information.

Patient/legal representative signature: _____**Date:** _____

Specify relationship if not patient: _____