

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION  
DELTA DENTAL OF SOUTH DAKOTA**

I \_\_\_\_\_ (Print Name) hereby authorize the use and disclosure of my health information by Delta Dental of South Dakota as described in this authorization.  
Subscriber ID#: \_\_\_\_\_

1) *Specific person/organization (or class of persons) authorized to receive and use the information:*

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2) *Specific description of the information you are authorizing us to release:*  
(For example, relevant dental information associated with claims received by Delta Dental of South Dakota.)

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3) *Purpose of the request:*  
(Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual.")

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4) I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

5) I understand that I am entitled to receive a copy of this authorization.

6) I understand that this authorization will expire when I am no longer a subscriber with Delta Dental of South Dakota.

7) Payment, enrollment or eligibility will not be conditioned on obtaining an authorization.

8) *Right to revoke:* I understand that I have the 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 is only effective after it is received and logged by Delta Dental of South Dakota. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

Signature of Individual \_\_\_\_\_

Date \_\_\_\_\_

*Personal Representatives Section*

If a Personal Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the basis of: \_\_\_\_\_