Authorization to Release Information

DELTA DENTAL®

Delta Dental of Nebraska

WHEN TO USE THE FORM

- You must complete this form if you want Delta Dental of Nebraska (DDNE) to give Protected Health Information (PHI) about you to someone else (for example: your spouse, your daughter or son, or a friend.)
- Please remember that your treating dental provider already has access to your PHI.
- Parents or a legal guardian must sign for a minor.

HOW TO COMPLETE THE FORM

This Authorization to Release Information (ATRI) form must be *completed, signed* and *dated* in order to be valid by one of the following:

- The member whose PHI will be released; or
- The parent or legal guardian of a minor whose PHI will be released; or
- The Personal Representative of the member whose PHI will be released.
  Note: In this instance in addition to the completed ATRI form, also send us a copy of the document which appoints the individual to be the Personal Representative of the member whose PHI is to be released: (e.g. power of attorney (POA), conservator, legal guardian, executor).

TO COMPLETE THE FORM

- Print the first and last name as well as the middle initial of the member whose PHI will be released, as well as his or her date of birth. In addition, also provide the member's ID number which can be found on the ID card of the member noted above. Check the type(s) of information you want us to release.
- Print the first and last name as well as the complete address of the person or organization who will receive the PHI.
- Check the applicable purpose of the release.
- If you would like the release to be valid for more than one year, indicate the date of expiration.
- Read the Member Authorization section of the form.
- Sign and date the form.
- If you are not the member whose PHI will be released, state your name and relationship to the member.

MAIL OR FAX THE FORM TO

Attn: Privacy Officer
Delta Dental of Nebraska
500 Washington Ave. South, Suite 2060
Minneapolis, MN 55415

Secure Fax # (612) 460-3102

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Member Name: _____ Date of Birth: _____

Member's 9-Digit ID Number (Located on Delta Dental of Nebraska ID card): _____

I authorize Delta Dental of Nebraska to release: (check one of the two choices below)

- ❑ All of my information
- ❑ Only the following information (please specify): _____

Delta Dental of Nebraska may release this PHI to:

Name: _____

Street Address: _____

City, State, Zip _____

Purpose of Release: This disclosure is being made for the following purpose:

- ❑ At my request
- ❑ Other (please specify): _____

Expiration Date: This authorization expires one (1) year from the date signed **OR** on the date or event indicated:_____

Member Authorization: I understand that:

- The person(s) or organization(s) I have named to receive PHI may not be subject to privacy laws. The recipient may redisclose my information, and it may no longer by protected under privacy laws.
- I may revoke this authorization in writing. If I revoke this authorization, it will not affect any disclosures already made before the date of revocation.
- Under the law, Delta Dental of Nebraska may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization unless the authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment.

Member Signature:_____ Date: _____

Signature of Member

OR

_____ Date: _____

*Signature of Parent (if Member is a minor), Guardian, or Personal Representative of Member**

(*Include the document which appoints the Personal Representative)

If you are a parent, guardian, or personal representative signing on behalf of the Member, please provide the following:

Name: _____ Relationship to Member: _____

Note: You have a right to keep a copy of this form after you sign it.