DELTA DENTAL®

Authorization for the Disclosure of Protected Health Information

I authorize Delta Dental of Kansas, Inc. (DDKS) to disclose my protected health information to the following person(s) for the described purposes only:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Information to be Disclosed: _____

Purpose for Disclosure: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ ZIP: _____

Information to be Disclosed: _____

Purpose for Disclosure: _____

1. This authorization expires on (insert date or event): _____

2. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed by that person or entity and would no longer be protected.

3. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and sent to: Finance Department, Delta Dental of Kansas, Inc., PO Box 789769, Wichita, Kansas 67278-9769. I am aware that my revocation is not effective to the extent that DDKS has previously disclosed my protected health information in reliance upon this authorization.

4. I certify that I have read and understand this form and that I am the enrollee identified or am authorized to act on behalf of the enrollee as a guardian or personal representative. I understand that I may have a copy of this form after I sign it.

Please sign this form and provide the required information below so that we may comply with your request. Completion of this form will not in any way affect your payment, enrollment or eligibility for benefits.

Enrollee Name: _____ Member ID #: _____
(Please Print) (Found on your Member ID card)

Date of Birth: _____

Enrollee Signature: _____ Date: _____

Personal Representative Name:_____ Relationship to Patient: _____
(If applicable. Please Print)

Date of Birth: _____

Personal Representative Signature: _____ Date: _____

Return to Delta Dental of Kansas:
email: claims@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3392

800.234.3375 | DeltaDentalKS.com

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