Authorization for the Disclosure of Protected Health Information

Please print all information except for required signature.

Member Name: _____ Member ID #: _____ (Found on your Member ID card) Date of Birth: _____

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

Employer Name (If applicable) : _____

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED:

- ❒ Demographic Information
- ❒ Payment Records
- ❒ Dental Records
- ❒ Other Medical Records
- ❒ Billing Records
- ❒ Other: _____
- ❒ Eligibility/Benefits
- ❒ All Records*

If you wish to further limit the information boxes you checked above (i.e. specific dates of service, specific case management issues, etc.), please specify that in the space provided: _____

_____

*"All records" means all protected health information in a designated record set, which may include but is not limited to member family histories, genetic information, dental, sexually transmitted diseases, other communicable diseases, mental or behavioral health services, treatment for alcohol or drug abuse, HIV/AIDS, physician records, office notes, narrative summaries, telephone messages, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices (this includes all records including records from other health care providers).

I authorize Delta Dental of Kansas to use and/or disclose the PHI described above to:

_____

I authorize Delta Dental of Kansas to use and/or disclose the above information covering the following timeframe:
From: _____ To: _____
Expiration: If you did not specify a limitation above, this 'Authorization' shall remain effective for 60 days after the date listed below.

1. This request for disclosure of medical records/information is made at my request for (state reason for the disclosure): _____ .
2. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be re-disclosed and are no longer protected by those regulations.
3. I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization.
4. I also understand that I may revoke this authorization at any time by delivering/mailing a written revocation to the Delta Dental of Kansas Privacy Officer, P.O. Box 70201, London, KY 40742.
5. If I revoke this authorization it will have no effect on actions already taken on reliance of this form.
6. I also understand that the covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it.
7. I authorize the disclosure of the records/information described. I have read and understand this form. I am the Member listed or am authorized to act on behalf of the Member as the Member's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.
8. If I am the legal representative for the Member, I have attached copies of my legally sufficient authorization to act on behalf of the Member (e.g. healthcare power of attorney, living will, guardianship papers, etc.). If I do not attach the documentation required, I understand Delta Dental of Kansas will not release the information requested until I do so.

Member Signature: _____ Date: _____

Personal Representative* Name: _____ Date of Birth: _____
(If applicable)

Relationship to Member: _____

Personal Representative* Signature: _____ Date: _____

Address of Personal Representative: _____ Phone Number: _____

*Sufficient authorization to act on behalf of Member (e.g. healthcare power of attorney, living will, guardianship papers, etc.) required.

Return to Delta Dental of Kansas:
email: claims@deltadentalks.com | mail: P.O. Box 70201, London, KY 40742 | fax: 316.462.3392

800.234.3375 | DeltaDentalKS.com

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