



**INDIVIDUAL AUTHORIZATION**

(This document grants Delta Dental of Iowa authority to use and/or disclose Protected Health Information (PHI) or to receive PHI from another entity.)

**Individual Authorizing use and/or disclosure of PHI**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone # \_\_\_\_\_ E-Mail \_\_\_\_\_

Delta Dental ID Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Description of Protected Health Information**

Provide a specific and meaningful description of the PHI you are authorizing for use and/or disclosure. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Purpose of this authorization**

Request of Individual \_\_\_\_\_ Other (please describe) \_\_\_\_\_

\_\_\_\_\_

**Who may use and/or disclose this information**

Identify the persons and/or organizations (including Delta Dental of Iowa) you are authorizing to use and/or disclose the PHI described above.

\_\_\_\_\_

**Who may receive this information**

Identify the persons and/or organizations (including Delta Dental Plan of Iowa) you are authorizing to use and/or receive the PHI described above.

\_\_\_\_\_

