Authorization to Release Protected Health Information Form

Fill out this form to let Delta Dental share your protected health information (PHI) with the person or entity you choose. Delta Dental includes Delta Dental of Iowa and Veratrus Benefit Solutions, Inc.

Member giving Delta Dental permission:
Name: ______________________________
Address, City, State, Zip: ______________________________
Telephone: ______________________________
Email: ______________________________
Delta Dental ID Number, Medicaid ID Number, or Social Security Number: __________
Group Name (if applicable): ______________________________

If you have other Delta Dental coverage, please provide the following information:
Other Group Name: ______________________________
Delta Dental ID Number or Medicaid ID Number: ______________________________
Does this request apply to all Delta Dental coverage?

- ☐ Yes
- ☐ No

Who can use or share your PHI?: Delta Dental

Person or Entity who can get your PHI:
Person/Entity Name: ______________________________
Address, City, State, Zip: ______________________________
Telephone: ______________________________
Your Relationship with the Person or Entity: ______________________________

PHI to be shared:
Tell us what information you want to share. You can choose to only share certain details. For example,

- ☐ Claims: ______________________________
- ☐ Eligibility/Benefits: ______________________________
- ☐ Premium & Payment Information: ______________________________
- ☐ Other: ______________________________

Why are you sharing this PHI?:
Please describe the reasons for sharing this information. If you don't want to say why, you can check the box that says “At My Request”

- ☐ At My Request
- ☐ Reasons (please describe): ______________________________

<u>EXPIRATION:</u> You can pick a date or event when this authorization will expire. You can change or cancel it at any time.

☐ This permission to share my information lasts until ________/_______/_______
Month Day Year

Or

☐ After the event described below happens. The event must be about the person or the reason for sharing the information. For example, the form can end when treatment ends, insurance stops, or a lawsuit is finished.

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If you don't give us an expiration date or event, this form will automatically expire one year after Delta Dental gets your completed form with all the needed information.

Important Information:

- This notice and form tells you how your PHI may be used or disclosed. Please read it.
- If something is missing, Delta Dental will return the form. We can't process it until it's complete.
- You do not have to let us use or share your information.
- You don't have to sign this form. Your services and benefits won't change if you don't sign.
- Delta Dental can't decide your treatment, payment, enrollment, or eligibility for benefits based on if you sign this form unless the law says we can.
- You will need to fill out a new form if you switch groups or if your benefits change to a different Delta Dental plan.
- Your information may not be protected by law when you share it. The person or entity you share it with may not have to follow privacy laws. If they have not signed an agreement with you, Delta Dental, or another party, your PHI may not be safe. They could share this information with others.
- This form only lets Delta Dental share the information you authorize. We will not share other medical or dental information.
- There are special protections for alcohol and drug abuse records and mental health records. Federal requirements under 42 CFR Part 2 and Iowa Code Chapter 228 protects these records. Delta Dental can only share this information with specific written consent from the patient or when allowed by law or regulations. This general authorization does not let Delta Dental share this information. This information cannot be used to criminally investigate a patient. This information cannot be used to prosecute for drugs or alcohol.

- Delta Dental shall not have liability when it discloses or uses your PHI according to this form.
- You may change or cancel this request at any time by sending a written request to:
  Delta Dental of Iowa
  Dental Wellness Plan
  P. O. Box 9040
  Johnston, Iowa 50131
  Fax: 888-264-0195
- Your right to cancel will *not* apply in the following situations:
  - any actions Delta Dental took on reliance of your request before Delta Dental received the request to cancel.
  - if Delta Dental obtained the Release as a condition for you to obtain insurance coverage and some law gives Delta Dental the right to contest a claim under the policy or the policy itself.
- *You will get a copy of this authorization. Keep it for your records. Delta Dental will also keep a copy. We can give you another copy if you ask.*

SIGNATURE OF INDIVIDUAL, PERSONAL REPRESENTATIVE,* OR PARENT/LEGAL GUARDIAN:** I have read this form. By signing, I confirm that I allow my protected health information to be used or shared as described in this form.

Signature: ______________________________ **Date:** ________/_____/______
Month Day Year

Printed Name: ____

* If this request is signed by a ***Personal Representative***:

- Describe the personal representative's authority to act for the member on this form. For example, the personal representative could be the member's legal guardian. ____
- To complete your request, we need documentation the personal representative can make these decisions. Examples could be a power-of-attorney, court order, or executor of estate document. If you haven't already filled out a Personal Representative Appointment form, please attach a completed form and any documents that show their authority. You can get a copy of the form by calling Delta Dental Customer Service at 1-888-472-2793.

** If a legal guardian signs for someone, they must give us a copy of the guardian appointment with this form. A parent or spouse can sign for someone 18 or older only if the person has filled out a Personal Representative Appointment form for Delta Dental. You can find Delta Dental's Personal Representative Appointment form on our DWP Kids website: https://www.deltadentalia.com/dwp/kids/forms/.

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full nondiscrimination statement, go to http://www.deltadentalia.com/nondiscrimination.

RETURN THIS COMPLETED FORM TO:

Delta Dental of Iowa
Dental Wellness Plan
P. O. Box 9040
Johnston, Iowa 50131
Fax: 888-264-0195

FOR QUESTIONS OR ASSISTANCE:

Call: 1-888-472-2793

Here is a list of terms or words that were used in this form to hopefully provide some additional clarity on the meaning or definition of those words. If you are still not sure what a term or word means in this form, please contact the number listed above.

Word	**Definition/Meaning**
Authorization:	The permission given by the member to use or share their protected health information.
Court Order:	A legal document issued by a court that requires a person to do or not do something.
Delta Dental of Iowa:	This is the dental company that provides dental services to its members. It works with Iowa Medicaid to provide dental services to members covered under Medicaid programs, such as the Dental Wellness Plan or Hawki.
Delta Dental ID Number:	A unique identifier assigned to a member by Delta Dental.
Executor of Estate:	A person appointed to administer the estate of a deceased person.
Medicaid ID Number:	A unique identifier assigned to individuals enrolled in Medicaid. The Medicaid ID Number is found on the member's Dental Wellness Plan or Hawki card and will have 7 numbers with 1 letter at the end, like 1234567A.
Personal Representative:	Someone who has legal authority to make decisions about your health care benefits, ask for your health information, and use all your rights under your Delta Dental plan, including appealing claims.
Power-of-Attorney:	A legal document that allows someone to act on your behalf.
Protected Health Information (PHI):	Any information Delta Dental has that can identify you, such as your date of birth or Member ID, and information about your health and payment for your healthcare.
Veratrus Benefit Solutions, Inc.:	This is a company that is part of Delta Dental of Iowa and provides vision services to its members.