



Personal Representative Appointment & Authorization to Release Protected Health Information

This form authorizes Delta Dental of Iowa to disclose protected health information at the request of the individual.

Individual Authorizing Disclosure

Name: _____
Address: _____
Telephone: _____
Hawki ID #: _____
Email Address: _____
(Provide only if you want to be emailed)

Personal Representative Appointment

I appoint the individual named below to act on my behalf as my Authorized Personal Representative with Delta Dental of Iowa in connection with: {Check all that you want to apply}

- ☐ All my claims or inquiries for dental benefits on and after the effective date of this appointment.
- ☐ My inquiries and claims for dental benefits with the following dates of service: _____
{specify dates}
- ☐ All inquiries and claims for dental benefits for the following minor dependent(s): _____
{Specify names}
- ☐ My appeal of services or claim(s) with the dates of: _____
{specify dates}

Personal Representative

Name: _____
Address: _____
Telephone: _____
Hawki ID #: _____
Email Address: _____
(Provide only if you want to be emailed)

Effective: This appointment of an Authorized Personal Representative and authorization to disclose is effective upon Delta Dental of Iowa's receipt of the fully completed and signed original or exact copy of this form at the address stated below.

Expiration: This appointment and authorization will expire 30 days after termination of my dental benefits or upon settlement of my claims incurred while covered, unless revoked or an earlier date or event is entered below.

- ☐ On ____/____/____ (date) OR
- ☐ On occurrence of the following event (which must relate to the individual or the purpose of the use and/or disclosure being authorized): _____

Right to Revoke: I understand I may revoke this appointment and authorization at any time by giving written notice of my revocation to Delta Dental of Iowa at the address stated below. I understand revocation of this appointment and authorization will *not* affect any action you took in reliance on this appointment and authorization before you received my written notice of revocation.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected Health Information to be Disclosed: I authorize Delta Dental of Iowa to disclose the protected health information described in this form to the named Authorized Personal Representative.

This authorization shall include and apply to any and all protected health information related to treatments where the individual has requested a restriction and/or for any health care item or service for which the health care provider/dentist has been paid out of pocket in full.

Effect of Granting this Authorization: I understand if the person or entity that receives the information requested is not covered by federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

Prohibition on Redisclosure: This form does not authorize the disclosure of medical/dental information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and state requirements (Iowa Code Chapter 228) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical/dental or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

No Conditions: This authorization is voluntary. Delta Dental of Iowa does not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

I have had full opportunity to read and consider the contents of this personal representative appointment and authorization, and I understand that, by signing this form, I am confirming my authorization of the disclosure of my protected health information, as described in this form.

Signature: _____
Individual's Signature (or Legal Guardian, if applicable)

Date: ____/____/____
Signature Date Required

Print Name of Legal Guardian if applicable*

**If a legal guardian signs for an individual, a copy of the guardian appointment must be submitted with this form.*

RETAIN A COPY FOR YOUR RECORDS – Send completed and signed form to:

Delta Dental of Iowa
P.O. Box 9040
Johnston, IA 50131

Delta Dental of Iowa Required Federal Notice- Nondiscrimination and Accessibility

Nondiscrimination Notice

Delta Dental of Iowa complies with all Federal civil rights laws that relate to healthcare services. We do not discriminate against people because of their race, color, national origin, age, disability, or sex. This means we will not treat you differently because of these things. To review our full nondiscrimination notice, go to completo, visit www.deltadentalia.com/nondiscrimination.

Language Assistance- Communicating with you is important to us.

Member Services: 1-800-544-0718 (TTY: 1-888-287-7312).

English: Language help services, including, auxiliary aids and services, larger font, written translation or oral interpretation, and alternative formats are available to you at no cost. To get this, please call the number above.

Spanish (Español): Los servicios de ayuda con idiomas, que incluyen ayudas y servicios auxiliares, letras más grandes, traducción escrita o interpretación oral, y formatos alternativos, están disponibles para usted sin costo alguno. Para obtenerlos, llame al número que aparece arriba.

Arabic (العربية): خدمات المساعدة اللغوية، بما في ذلك أدوات المساعدة والخدمات الإضافية، والخط الأكبر، والترجمة المكتوبة أو الترجمة الشفوية، والتنسيقات البديلة متاحة لك مجاناً. للحصول على هذه الخدمات، يُرجى الاتصال بالرقم الموجود في الأعلى.

Chinese (中文): 您可以免费获得语言帮助服务，包括辅助工具和服务、更大的字体、书面翻译或口译以及其他格式。如需获取此服务，请拨打上述的电话号码。

French (Français): Les services d'assistance linguistique, y compris les aides et services auxiliaires, les polices de plus grande taille, la traduction écrite ou l'interprétation orale ainsi que d'autres formats, sont à votre disposition gratuitement. Pour obtenir ces services, veuillez appeler le numéro ci-dessus.

German (Deutsch): Sprachunterstützungsdienste, einschließlich Hilfsmittel und -dienste, größere Schriftarten, schriftliche und mündliche Übersetzungen sowie alternative Formate stehen Ihnen kostenlos zur Verfügung. Um diese zu erhalten, rufen Sie bitte die oben genannte Nummer an.

Hindi (हिंदी): भाषा सहायता सेवाएँ, जिनमें अतिरिक्त सहायता और सेवाएँ, बड़े फ़ॉन्ट, लिखित अनुवाद या मौखिक व्याख्या तथा वैकल्पिक प्रारूप शामिल हैं, आपके लिए निःशुल्क उपलब्ध हैं। इसे प्राप्त करने के लिए कृपया ऊपर दिए गए नंबर पर कॉल करें।

Karen (ကုဏ္ဍိ): ကျိတ်တိတ်မၤစၢၤ ဟံးဃုာ်ဒီး ပီးလိမၤစၢၤ ဒီး တၢ်မၤစၢၤ လၢအဘိဉ်ညိလၢပဲၤ အလံာ်ဖျါၣ်ဖးဒိၣ် တၢ်ကွဲးကျိတ်ထံ မ့တမ့ၢ် တၢ်ကတိၤကျိတ်ထံ ဒီး သဒ္ဒါလၢအဂၤၤ တဖၣ်အိၣ်လၢနီၢ်လၢတဘျီလၢအဘျးလဲၣ်န့ၣ်လၢၤ လၢကမၤန့ၢ်အိၣ်အိၣ် ဝံသးစူၤကိၢ်လိတဲၣ်နီၣ်ဂံၢ်ဖျါလၢထးတက့ၢ်.

Korean (한국어): 보조 기구 및 서비스, 대형 활자, 서면 번역 또는 구두 통역 및 대체 형식을 포함한 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이러한 서비스를 이용하시려면 위 번호로 전화하십시오.

Laotian (ພາສາລາວ): ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ລວມທັງການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມ, ໂຕພິມໃຫຍ່, ການແປເປັນລາຍລັກອັກສອນ ຫຼື ການແປປາກເປົ່າ ແລະ ຮູບແບບອື່ນໆໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ເພື່ອຮັບບໍລິການເຫຼົ່ານີ້, ກະລຸນາໂທໄປທີ່ເບີຂ້າງເທິງນີ້.

Pennsylvania Dutch (Deitsch): Hilf mitt di shprohch, mitt anri hilf un deenshta, graysah shreives, en kshrivveni translation adda en oral interpretation un anri formats sinn dich ohgebodda unni kosht. Fa dess greeya, please du da nummah do ovvva droh ufroofa.

Russian (Русский): Услуги языковой помощи, в том числе вспомогательные средства и услуги, крупный шрифт, письменный или устный перевод, а также альтернативные форматы предоставляются бесплатно. Для получения такой помощи позвоните по указанному выше номеру.

Serbo-Croatian (Srpsko-hrvatski): Pomoćne usluge koje se tiču jezika, uključujući pomoćna sredstva i usluge, veći font, pisani prevod ili usmeno tumačenje i alternativne formate, dostupne su Vam besplatno. Da biste ih dobili, pozovite gore navedeni broj telefona.

Tagalog (Tagalog): Ang mga serbisyong tulong sa wika, kabilang ang mga panghaliling tulong at serbisyo, mas malaking font, nakasulat na pagsasalin o pasalitang interpretasyon, at mga alternatibong pormat ay handa mong magamit nang walang bayad. Para makuha ito, pakitawagan ang numero sa itaas.

Thai (ภาษาไทย): บริการความช่วยเหลือเรื่องภาษา รวมทั้งความช่วยเหลือและบริการเสริม ตัวอักษรขนาดใหญ่ การแปลงข้อความหรือสามแปลททางวาจา และบริการทางเลือกรูปแบบอื่นที่พร้อมให้บริการโดยไม่มีค่าใช้จ่าย เพื่อรับบริการนี้ โปรดโทรติดต่อหมายเลขข้างต้น.

Vietnamese (Tiếng Việt): Các dịch vụ trợ giúp ngôn ngữ, bao gồm các dịch vụ và hỗ trợ phụ trợ, phông chữ lớn hơn, bản dịch bằng văn bản hoặc phiên dịch bằng miệng và các định dạng thay thế được cung cấp miễn phí cho quý vị. Để nhận được thông tin này, vui lòng gọi đến số điện thoại ở trên.

For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call TTY:1-888-287-7312.

Para recibir asistencia de accesibilidad por teléfono si es sordo, tiene problemas de audición, es sordociego o tiene dificultades para hablar, llame al TTY: 1-888-287-7312.