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.

<u>Individual Authorizing Disclosure</u>

Name: ____

Address: ____

Telephone: ____

DWP ID #: ____

Email Address: ____

(Provide only if you want to be emailed)

<u>Personal Representative Appointment</u>

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}

<u>Personal Representative</u>

Name: ____

Address: ____

Telephone: ____

DWP ID #: ____

Email Address: ____

(Provide only if you want to be emailed)

<u>Effective:</u> 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.

<u>Expiration:</u> This appointment and authorization will expire 30 days after termination of my dental benefits or upon settlement of my claims incurred while covered, <u>unless</u> 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: ____ **Date:** ____/_____/_____

Individual's Signature (or Legal Guardian, if applicable) 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
Medicare Advantage
P.O. Box 9040
Johnston, IA 50131