# Authorization to Release Information

DELTA DENTAL®

Delta Dental of Minnesota

**WHEN TO USE THE FORM**

- You must complete this form if you want Delta Dental of Minnesota (DDMN) to give Protected Health Information (PHI) about you to someone else (for example: your spouse or a friend.)
- Please remember that your treating dental provider already has access to your PHI.
- A parent or a legal guardian must sign for a minor.

**HOW TO COMPLETE THE FORM**

**This Authorization to Release Information (ATRI) form must be *completed, signed* and *dated* by one of the following in order to be valid:**

- The member whose PHI will be released; or
- The parent of a minor whose PHI will be released; or
- The Personal Representative or Legal Guardian of the member whose PHI will be released. ***Note:*** *In these instances, a complete copy of the document which appoints the Personal Representative or Guardian of the member is required: (e.g. power of attorney (POA), conservator, legal guardian, executor).*

**TO COMPLETE THE FORM**

- Print the first name, last name, and the middle initial of the member whose PHI will be released.
- Print the members date of birth and member ID number found on the Delta Dental of Minnesota ID card.
- Check the type(s) of information you want us to release.
- Print the first name, last name, and address of the person or organization who will receive the members PHI.
- Check the applicable purpose of the release.
- If you would like the release to be valid for more than one year, indicate the date of expiration.
- Read the Member Authorization section of the form.
- Sign and date the form. *Note: If you are completing the form electronically, you will need to print the form prior to signing. E-signatures are not accepted at this time.*
- If you are not the member whose PHI will be released, print your name and relationship to the member. Include the document which appoints you as Personal Representative or Legal Guardian.

**SUBMIT THE FORM AND ATTACHMENTS:**

Mail: Attn: Privacy Officer
Delta Dental of Minnesota
500 Washington Ave. South, Suite 2060
Minneapolis, MN 55415

Secure Fax: (612) 460-3102

Email (*pdf attachments only): ATRI@deltadentalmn.org

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Member Name: _____ Date of Birth: _____

Member 8 or 9 digit ID Number (Located on Delta Dental of Minnesota ID card):_____

I authorize Delta Dental of Minnesota to release: (check one of the two choices below)

- ❑ All of my information
- ❑ Only the following information (please specify): _____

Delta Dental of Minnesota may release this PHI to:

Name: _____

Street Address: _____

City, State, Zip _____

**Purpose of Release:** This disclosure is being made for the following purpose:

- ❑ At my request
- ❑ Other (please specify): _____

**Expiration Date:** This authorization will expire one (1) year from the date signed **OR** on the expiry date or event indicated on this line:_____

**Member Authorization:** I understand that:

- The person(s) or organization(s) I have named to receive PHI may not be subject to privacy laws. The recipient may redisclose my information, and it may no longer by protected under privacy laws.
- I may revoke this authorization in writing. If I revoke this authorization, it will not affect any disclosures already made before the date of revocation.
- Under the law, Delta Dental of Minnesota may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization unless the authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment.

**Member Signature:**_____ **Date Signed**: _____

**OR**

**Representative Signature:** _____ **Date Signed:** _____

*Example: Parent (if Member is a minor), Guardian, or Personal Representative of Member**

***If you are signing on behalf of the member, attach a copy of the document which appoints you as Guardian or Personal Representative (ex. Power of Attorney) and complete the following:**

Name: _____ Relationship to Member: _____

**Note:** You have a right to keep a copy of this form after you sign it.