DELTA DENTAL

Delta Dental of Colorado
Health Insurance Portability and Accountability Act (HIPAA) Authorization Form for Disclosure of Personal Health Information (PHI)

Please complete all sections of this HIPAA authorization form. The form is invalid unless signed and complete.

Subscriber Information

First/Last Name of Subscriber:

Member ID Number or Social Security Number (SSN) of Subscriber:

Identity of member's information to be released (only complete if different from above)

First/Last Name of Member:

Date of Birth:

Member ID Number or SSN:

I authorize the use or disclosure of information that includes my protected health information by Delta Dental of Colorado (DDCO) as described below.

1. The following person, class of persons, or business (third party) may receive disclosures of my protected health information:

    a. Name:

    b. Business/Company (if applicable):

    c. Phone:

    d. Physical Address:

    e. Email Address:

2. The specific information that should be disclosed is (please be specific and include dates if possible):

3. I understand that the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying **HIPAA@ddpco.com** in writing. However, I understand that my revocation will not affect any action already taken.

5. My information will be disclosed for the following purpose(s):

6. This authorization is valid until termination of enrollment or upon my revocation. If this authorization is for a minor, it will expire upon the minor's 18th birthday.

Member Name:

Relationship to Member:

Signature: (Individual authorizing release of information)

Date: