

**HIPAA AUTHORIZATION  
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

Printed Patient Name \_\_\_\_\_ Previous Names, If Applicable \_\_\_\_\_  
Date of Birth \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Daytime Telephone Number

**RELEASE INFORMATION TO:** (or "personal representative")

Name (or Organization): \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_ Fax #: \_\_\_\_\_

**INFORMATION TO BE RELEASED FROM OR USED BY:** (please be specific)

Organization: **Delta Dental/Washington Dental Service**  
Address: PO Box 75983, Seattle, WA 98175-0983  
Phone #: 800-554-1907 Local #: 206-522-1300 Fax #: 800-691-4960

**PURPOSE OF USE OR DISCLOSURE:**  Specialty Care  Self  Other \_\_\_\_\_

**INFORMATION TO BE USED OR DISCLOSED:**

- Information "as needed" to "Personal representative" authorized by patient
  - Claim Records from previous year
  - Summary Coverage Information
  - Complete Designated Record Set
  - Other \_\_\_\_\_
- Dates of Treatment (Service): \_\_\_\_\_

\_\_\_\_\_  
Date Signature of patient or representative Relationship to patient

**Authorization Expiration Date (or event)** \_\_\_\_\_ (six month standard unless otherwise noted)

If the patient is unable to sign, please indicate such and your authority to act for the patient. This form must be dated within 90 days of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions on how to revoke this authorization. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected  
**Please note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.**

For Washington Dental Service Use:					
Date Received: _____	Date Information Released: _____	Sub # _____			
PHI disclosed via: _____	Mail o	Fax o	Phone o	Picked up by requestor o	Delivered by patient o