

# Authorization to Release Information

Please read these instructions carefully before completing this form.

## When to Use This Form

You must complete this form if you want Delta Dental of Minnesota to give information about you to someone else (for example, your spouse or friend).

Please remember that your treating dental provider already has access to your information.

Parents or a legal guardian may sign for a minor.

## How to Complete This Form

This Authorization for Release of Information form must be completed and signed by:

- The person whose information will be released; or
- The parent or legal guardian of a minor whose information will be released; or
- The personal representative of the person whose information will be released (e.g. power of attorney, conservator, legal guardian, executor).

To complete this form:

- Fill in the name, ID number and date of birth of the person whose information will be released.
- Check the type(s) of information you want us to release.
- Fill in the name and address of the person or organization who will receive the information.
- Sign and date the form
- If you are not the person whose information will be released, state your relationship to that person.

## Mail or fax this form to:

Attn: Privacy Officer  
Delta Dental of Minnesota  
PO Box 9304  
Minneapolis, MN 55440-9304

Fax: (651) 406-5955

# Authorization to Release Information

## Member Information (person granting release of information)

Member Name: \_\_\_\_\_

Subscriber's 9-Digit ID Number (on ID card): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize Delta Dental of Minnesota to release:

Any and All Information Requested

Only the following information: \_\_\_\_\_

## Delta Dental of Minnesota may release this information to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that the person(s) I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it.

## Right to Revoke

I understand that I may cancel this Authorization at any time, but it will not affect any release of information completed before I cancel it.

**Expiration Date:** This Authorization is valid (please check one box):

for six (6) years after the date it's signed

until \_\_\_\_\_ (specify date)

\_\_\_\_\_  
Signature of Member

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

Date: \_\_\_\_\_

(only if authorizing release of a minor's information)

If you are a Personal Representative completing this form on behalf of a Member, please complete the following:

Signature of Personal Representative \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

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