

## 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, your daughter or son, or a friend.)
- Please remember that your treating dental provider already has access to your PHI.
- Parents 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* in order to be valid by one of the following:

- The member whose PHI will be released; or
- The parent or legal guardian of a minor whose PHI will be released; or
- The Personal Representative of the member whose PHI will be released.  
*Note: In this instance in addition to the completed ATRI form, also send us a copy of the document which appoints the individual to be the Personal Representative of the member whose PHI is to be released: (e.g. power of attorney (POA), conservator, legal guardian, executor).*

## TO COMPLETE THE FORM

- Print the first and last name as well as the middle initial of the member whose PHI will be released, as well as his or her date of birth. In addition, also provide the member's ID number which can be found on the ID card of the member noted above. Check the type(s) of information you want us to release.
- Print the first and last name as well as the complete address of the person or organization who will receive the 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.
- If you are not the member whose PHI will be released, state your name and relationship to the member.

## MAIL, FAX, OR EMAIL THE FORM TO

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

Secure Fax #: (612) 460-3102

Email: [ATRI@deltadentalmn.org](mailto:ATRI@deltadentalmn.org)

*Note: Emailed ATRI forms and Personal Representative documents must be attached as a PDF, other formats will not be accepted.*

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

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

Member's 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 expires one (1) year from the date signed **OR** on the date or event indicated: \_\_\_\_\_

**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 be 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: \_\_\_\_\_

*Signature of Member*

**OR**

\_\_\_\_\_

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

*Signature of Parent (if Member is a minor), Guardian, or Personal Representative of Member\**

(\*Include the document which appoints the Personal Representative)

If you are a parent, guardian, or personal representative signing on behalf of the Member, please provide the following:

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

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

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