**FAX TO (405) 241-0737** Please allow seven (7) business days for processing. DELTA DENTAL OF OKLAHOMA

INCOMPLETE FORMS WILL NOT BE ACCEPTED.

**AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION**
**FOR PURPOSES REQUESTED BY CLAIMANT / PERSONAL REPRESENTATIVE**

I, _____ (hereinafter "*Claimant"* or *"Personal Representative*"), hereby request and authorize **Delta Dental of Oklahoma** (hereinafter "*DDOK*"), to disclose protected health information about _____ (Claimant or dependent under age 18) to _____ (Person authorized to receive information) for the sole purpose of assisting Claimant with their request, including assisting with Treatment, Payment or Health Care Operations, including claim processing questions. Claimant further requests and authorizes DDOK to release the minimum necessary information in order to properly assist in the claim processing questions regarding dental services received on _____ (must be specific). The information to be disclosed will be exclusively related to the treatment date(s), and will only include information necessary to assist in responding to the request, pursuant to the specific request of the claimant. Purpose of the disclosure: _____

- I acknowledge the receipt of a copy of this Authorization prior to its transmission to DDOK.
- This Authorization shall be in force and effect for thirty (**30) calendar days** after the date shown below, at which time this authorization to use or disclose the protected health information will expire.
- I understand that I have the right to revoke this authorization in writing, and by sending a revocation to the Chief Privacy Officer, Delta Dental of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154. I understand any revocation will not be effective until received by DDOK.
- I understand that information used or disclosed relating to this Authorization may be subject to re-disclosure and may no longer be protected by federal or state law.
- **The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.***
- I understand that I have the right to:
  Inspect or copy the protected health information to be used or disclosed as permitted under federal law; Refuse to sign this Authorization. Refusal to sign this Authorization will prohibit DDOK from disclosing the requested information to the Personal Representative. DDOK will not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on the individual's providing authorization for the requested use or disclosure.

**Description of Personal Representative Authority**

□ Parent □ Foster Parent □ Other, please specify: _____

□ Guardian □ Power of Attorney

_____ _____
Subscriber's Social Security Number or Identification Number

Signature of Claimant / Personal Representative

_____ _____
Recipient of Authorization

Date of Claimant Signature

_____ _____
Telephone Number

Group Number