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 DeCare Dental to give information about you to someone else (for example, your spouse, or a friend.)
- Please remember that your treating dental provider already has access to your information.
- Parents or a legal guardian may sign for a minor.

Who should 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 guardian of a minor whose information will be released; or
- The personal representative of the person whose information will be released. Include the document which appoints the Personal Representative (e.g. power of attorney, conservator, legal guardian, executor).

How to complete this form:

- Fill in the name, address, date of birth, and subscriber ID number of the person whose information will be released.
- Check the type(s) of information you want us to release.
- Fill in the name and relation 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 the completed form to:

DeCare Dental
Attn: Privacy Officer
P.O. Box 9304
Minneapolis, MN 55440-9304

Fax: 855-808-2014

Authorization to Release Information

Member Information (person granting release of information)

Member Name: _____

Member Address: _____

Member Date of Birth: _____

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

I authorize DeCare Dental to release:

- ❑ Any and All Information Requested
- ❑ Only the following information: _____

DeCare Dental may release this information to:

Name: _____ Relation: _____

Name: _____ Relation: _____

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 Protected Health 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: Check one box to signify when this Authorization is valid:

- ❑ For six (6) years after the date it's signed which is the maximum time allowed.
- ❑ Until (specify date if less than six (6) years): _____

_____ Date: _____

Signature of Member

_____ Date: _____

Signature of Parent
(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 and include the appropriate documentation (e. g. Power of Attorney):

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.