DELTA DENTAL

Delta Dental of New Mexico

Individual Authorization For Release of Protected Health Information

Name of Enrolled Person: _____
(Individual whose information will be used or released)

Address: _____

Date of Birth: _____

Telephone (daytime): _____

Name of Primary Subscriber: _____

Social Security Number (or ID #) of Primary Subscriber: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

Persons/organizations authorized to release my information: _____

Persons/organizations authorized to receive my information:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Specific description of my information to be used or released (including date(s)): _____

_____

Specific purpose of the release: _____

_____

Expiration date of this Authorization: _____
(indicate specific date, or an event relating to you personally)

I have read and understood the following statements about my rights:

- This Authorization is voluntary. I may refuse to sign it.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).
- I understand that the above-named persons/organizations authorized to receive the information may not be subject to privacy laws and may share my information further. I have the right to seek assurances from them that they will not release the information to any other party without my further authorization.
- I may cancel this Authorization at any time prior to its expiration date by notifying the providing organization in writing, but the cancellation will not have any affect on any release of my information that may occur before I cancel it. To cancel this Authorization, please send a written statement to Delta Dental of New Mexico, Operations Manager, 2500 Louisiana Blvd NE Suite 600, Albuquerque, NM 87110 and state that you are canceling this Authorization.

Signature of Individual or Individual's Representative

_____ _____
Signature of Enrolled Person or Personal Representative Date

Printed name of personal representative: _____

Relationship to the person, description and documentation (please attach) of authority to act as representative: _____

When to Use This Form

You must complete this form if you want Delta Dental of New Mexico to give individually identifiable health information about you to someone else (for example: an insurance agent, employer or family member).

How to Complete This Form

Parents or a legal guardian may sign for a minor.

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 (for example: power of attorney, conservator, legal guardian, executor).

To complete this form:

- Fill in the name, address, telephone number and date of birth of the person whose information will be released;
- Fill in the name and social security number (or ID#) of the primary subscriber (employee covered by the group);
- Fill in the name and address of the person or organization who will receive the information;
- Describe the specific information to be released (for example: a specific claim or series of claims related to a treatment);
- Fill in an expiration date or event;
- Sign and date the form; and
- If you are not the person whose information will be released, state your relationship to that person and provide documentation to act as a personal representative.

Mail or Fax This Form to:

DeltaDental of New Mexico
Attn: Operations Manager
100 Sun Avenue NE, Suite 400 Albuquerque,
NM 87109
Fax: (505) 883-7444

How to Cancel this Authorization:

You may cancel this Authorization at any time by notifying Delta Dental of New Mexico in writing at the address shown above.