

**Appendix A-4  
Authorization Form**

**DELTA DENTAL OF ILLINOIS  
AUTHORIZATION FOR RELEASE OF INFORMATION**

By signing this form in Section F below, I authorize Delta Dental of Illinois to release my individually identified health information as described in Section B to the person or entity named in Section C below. I understand that this authorization is voluntary, that I may obtain a copy of this form and that I may revoke it at any time by submitting my revocation in writing to Delta Dental of Illinois.

Please complete the information in all sections.

**SECTION A: Individual Information**

Name of Individual: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

**SECTION B: Description of Information to be Released, Including Dates**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SECTION C: Name of Person(s) or Organization Authorized to Receive Information**

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

I understand that once the information is released to the designated person(s) set forth above, pursuant to this authorization, it may no longer be protected by federal privacy regulations.

