

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.

