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 friend).

Please remember that your treating dental provider already has access to your information.

Parents or a legal guardian may sign for a minor.

How to 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 legal guardian of a minor whose information will be released; or
- The personal representative of the person whose information will be released (e.g. power of attorney, conservator, legal guardian, executor).

To complete this form:

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

Attn: Privacy Officer
DeCare Dental
PO Box 29
Minneapolis, MN 55440-0029

Fax: (651) 406-5955

Authorization to Release Information

Member Information (person granting release of information)

Member Name: ____
Subscriber's 9-Digit ID Number (on ID card): ____________________________
Date of Birth: _______________

I authorize DeCare Dental to release:

- ☐ Any and All Information Requested
- ☐ Only the following information: ____

DeCare Dental may release this information to:

Name: ____
Address: ____

Name: ____
Address: ____

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 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: This Authorization is valid (please check one box):

- ☐ for six (6) years after the date it's signed
- ☐ until _________________________ (specify date)

_________________________________ 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:

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.