

# Authorization to Release Information

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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.

## 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 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).

### 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  
P.O. Box 29  
Minneapolis, MN 55440-0029

Fax #: 651-768-1309

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## 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: 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): \_\_\_\_\_

\_\_\_\_\_  
Signature of Member

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent  
(only if authorizing release of a minor's information)

Date: \_\_\_\_\_

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.