6705 Faith Dr.
Cheyenne, Wyoming 82009
307.632.3313
Fax 307.632.7309

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please type or print all information and complete the entire form.

Incomplete authorizations are invalid.

Last Name: _____ First Name: _____ Date: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Subscriber ID# : _____

Describe **specific** information to be disclosed and/or used by another party:

_____
_____
_____

What is the reason for disclosure of this information?

_____
_____
_____

I authorize Delta Dental of Wyoming, to release the personal dental information indicated above to the following:

Name: _____ Date of Birth: _____ /_____ /_____ Relationship: _____

Name: _____ Date of Birth: _____ /_____ /_____ Relationship: _____

Name: _____ Date of Birth: _____ /_____ /_____ Relationship: _____

Name: Willis Towers Watson Relationship: Benefit Consultants

This Release is valid until: _____ / _____ / _____
(enter date)

Over →

AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION

I have requested the use and/or disclosure of my personal health information as listed above and I understand that my information may no longer be protected if it has been disclosed to a person who is not bound by the HIPAA Privacy Rule. Delta Dental of Wyoming may not condition treatment, payment enrollment or benefits eligibility on my provision of this authorization. I understand that I may revoke this authorization unless Delta Dental of Wyoming has already taken action based on this authorization. I understand that I must provide a written request to revoke this authorization.

_____ _____ / _____ / _____
Signature* Today's Date
(If not the subscriber, verification of authority and relationship to the subscriber is required.)

_____ _____ / _____ / _____
Signature* Today's Date
(If subscriber is under the age of 18 a parent or guardian must sign.)

*Original signature must be included.

(When completed electronically, please print this document after filling in all the fields, sign, and return by fax or postal mail.)

Delta Dental of Wyoming Use Only

If someone other than the member is requesting this use and/or disclosure, the relationship and authority has been verified by (Indicate means):

_____

_____

Authorization is complete? ☐ Yes ☐ No Authorization is clear? ☐ Yes ☐ No

_____ _____ / _____ / _____
Signature* Today's Date