

FAX TO (405) 607-2190 (please allow time for processing)

DELTA DENTAL PLAN OF OKLAHOMA
AUTHORIZATION FOR CLAIMANT ASSISTANCE

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION
FOR PURPOSES REQUESTED BY CLAIMANT / PERSONAL REPRESENTATIVE

I, _____ (hereinafter "Claimant" or "Personal Representative"), hereby request and authorize **Delta Dental Plan of Oklahoma** (hereinafter "DDPOK"), to disclose protected health information about _____ to _____ for
(Name of Claimant) (Name of Person Receiving Information)
the sole purpose of assisting Claimant with their request, including assisting with Treatment, Payment or Health Care Operations, including claim processing questions. Claimant further requests and authorizes DDPOK to release the minimum necessary information in order to properly assist in the claim processing questions regarding dental services received on _____. The information to be disclosed will be exclusively related to the treatment date(s), and will only include information necessary to assist in responding to the request, pursuant to the specific request of the claimant.

- I acknowledge the receipt of a copy of this Authorization prior to its transmission to DDPOK.
- This Authorization shall be in force and effect for **10 business days** after the date shown below, at which time this authorization to use or disclose the protected health information will expire.
- I understand that I have the right to revoke this authorization in writing, and by sending a revocation to the Chief Privacy Officer, Delta Dental Plan of Oklahoma, P.O. Box 54709, Oklahoma City, Oklahoma 73154. I understand any revocation will not be effective until received by DDPOK.
- I understand that information used or disclosed relating to this Authorization may be subject to re-disclosure and may no longer be protected by federal or state law.
- I understand that I have the right to:
 - Inspect or copy the protected health information to be used or disclosed as permitted under federal law;
 - Refuse to sign this Authorization. Refusal to sign this Authorization will prohibit DDPOK from disclosing the requested information to the Plan Representative.

Policyholder's Social Security Number _____

Signature of Claimant / Personal Representative _____

Recipient of Authorization _____

Group No. _____

Date: _____

Description of Personal Representative Authority

- | | |
|--|--|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Other, Explain, attach: _____ |
| <input type="checkbox"/> Foster Parent | _____ |
| <input type="checkbox"/> Guardian | _____ |
| <input type="checkbox"/> Power of Attorney | _____ |