



PROTECTED HEALTH INFORMATION RELEASE FORM
(AUTHORIZATION)

A photocopy of this authorization shall be considered as effective and valid as the original

TO: DentaQuest
PO Box 2906
Milwaukee, WI 53224

FAX: 262-834-3452

RE: Member Name _____ Member ID _____ Member DOB _____

I hereby authorize and direct DentaQuest to release to (*individual, office, organization, etc. that you would like the health information released to*), any and all information for the above-named member, as designated below (*check the appropriate line*):

Eligibility information
 Complete claim/authorization history
 Other-Please describe the information being requested: _____

Please send the above via:

Mail to the following address: Address: _____
Address: _____
City: _____
State, Zip: _____

Fax to the following number (_____) _____

Please be aware that when the person or organization listed above receives this information, they may be able to share it with others without your permission. If they do so, federal and state privacy law may not protect the information.

Authorized By: _____
(Signature of member, or authorized representative*) _____ (Date form signed) _____

Please print name of person signing this form (Telephone number where you may be reached)

* Authority of person filing out this form to act on behalf of applicant member : _____

If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, a **copy of the applicable legal document must be attached**.

Please note: the permission granted to release information will remain valid unless noted specifically here by the member. Date of expiration : _____. If any time in the future you wish to revoke this authorization, please contact DentaQuest's Customer Service Department. If you cancel this permission, DentaQuest will be unable to take back any information they may have shared previously.