Delta Dental of Washington
Authorized Representative Form for Appeals

Claim #:		Date of Service:	

Your Information	
Patient Name:	
Address:	
Telephone # and/or E-mail:	

Authorization to Release Health Information for Appeals

- I authorize Delta Dental of Washington (DDWA) to disclose to the representative designated above, information relevant to my appeal including, but not limited to, medical records, claims and coverage information. I understand that this authorization is voluntary and DDWA will not condition benefit payments, enrollment, or eligibility for benefits upon the execution of this form.
- I understand that I may revoke this authorization at any time by sending a written statement to the mailing address at the bottom of this form. I further understand that if I revoke my authorization, it will not affect any actions already taken by DDWA based on this authorization.
- I understand that once DDWA has disclosed health information, the recipient may re-disclose it in some situations. If the Authorized Representative named above is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my Authorized Represented may further disclose my personal health information without my consent.
- I understand that I have the right to limit the information that DDWA may release under this authorization. Any such limitations must be made in writing and sent to the address listed below.
- This authorization will automatically expire upon completion of the Appeal filed.

Authorized Representative Information	
Name:	
Address:	
Relationship to Subscriber/Patient:	
Telephone # and/or E-mail:	

Signature

I have read this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that DDWA may use and/or disclose my personal health information to the person(s) named.

Patient Signature:		Date:	

Contact Information

Keep a copy for your records and submit the original to us by email at memberappeals@deltadentalwa.com, or by mail at Attn: Regulatory Coordinator 720 Washington Street, Colville, WA 99114.