

**Metropolitan Government of Nashville and Davidson County  
Authorization to Release Health Information**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Member's Phone: \_\_\_\_\_  
Phone: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

I hereby authorize Delta Dental to disclose my health information as described below.

The information is to be disclosed to the following persons or organizations:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Purpose. The purpose of the use or disclosure is:

- At the request of the member
- Other:

\_\_\_\_\_  
\_\_\_\_\_

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around \_\_\_\_\_ (*insert dates*):

The following billing and payment information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire \_\_\_\_\_.

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time by sending a written notice to the Plan. However, the revocation will not have any effect on any uses or disclosures the Plan may have made before the revocation was received.

- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- Information used or disclosed pursuant to this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.
- I have been provided with a copy of this authorization.
- I may refuse to sign this Authorization and that the Plan will not condition treatment on whether I sign this Authorization.

I certify that I am (*check whichever applies*):

- the member, and the identification that I have provided is true and correct.
- the member's personal representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the member is that of:  
\_\_\_\_\_.

A copy, facsimile, or electronic transmission of this signed authorization shall have the same effectiveness as an original.

Signed this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

Signature: \_\_\_\_\_  
 Print name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone No: \_\_\_\_\_

Witness: \_\_\_\_\_  
 Print Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Delta Dental PLAN OF TENNESSEE**  
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