DELTA DENTAL®
Delta Dental of California

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By signing below, I hereby authorize Delta Dental of California (Delta) to release any necessary medical information (within the meaning of Civil Code § 56.05(f)) regarding ___________________________________ (patient name), including but not limited to, patient records, charts, X-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations.

Delta is disclosing this information to the following recipient
(include identity and function):
____
____
____

The recipient of the information disclosed pursuant to this authorization may use this information only for the following purpose. The recipient may not further disclose this information to any third party.
Purpose:
____
____
____

This authorization is valid for one (1) year from the date of execution.
A copy of this form will be sent to the patient or their legal representative upon request.

Signed*: _______________________________ **Dated:** ____________________
**Patient, legal representative, or other person authorized under Civil Code § 56.11(c).*

Please print the following information:
Name: ____
Street Address: ____
City, State, Zip: ____
Phone: __(____)____