Delta Dental of Kansas Community Benefit Plan

Consent to Release Information

I attest that the information that I have provided is true and accurate. I understand that my information is electronically tracked in order to assess my program eligibility and for service coordination. The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and payment of services.

I understand that my information (demographic information, eligibility for services/referral information and/or presence in program), and that of the accompanying members of my household, may be shared among providers in order to provide case coordination and/or to expedite my access to needed services and resources. This information may be provided to providers by phone, email and/or written form in order to process a referral and/or secure payment to the correct account. My signature indicates that an agency representative has answered any questions I had about my privacy concerns.

This authorization for release of information is valid for three years from date of signature and is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification in writing. To revoke my permission, I understand I am required to provide this agency a written and signed statement that includes the date my permission was revoked. I further understand that revoking permission to share said information may directly affect my ability to remain in the program.

Name (print): ______________________________________ Date: __________________

Signature: ____ Date: __________________