



PROTECTED HEALTH INFORMATION RELEASE FORM  
(AUTHORIZATION OF REPRESENTATION)

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

TO: MassHealth and DentaQuest, LLC PO BOX 2906 Milwaukee, WI 53201-2906 or FAX: 262. 834-3450

Member Name \_\_\_\_\_ Member ID \_\_\_\_\_  
Member Date of Birth \_\_\_\_\_

I hereby appoint:

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

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

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship:  Family  Provider (NPI \_\_\_\_\_)  Other \_\_\_\_\_

as my representative and authorize this individual to act on my behalf. I authorize and direct DentaQuest to provide this individual any and all information requested, which may include Personal Health Information (PHI), as designated below (*check the appropriate box*):

Eligibility information  Complete claim/authorization history  Other (please describe below)

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Authorized By: \_\_\_\_\_  
(Signature of member, or authorized representative\*) (Date form signed)  
\_\_\_\_\_  
Please print name of person signing this form (Your telephone number)

\*Authority of person filing out this form to act on behalf of 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 for one year from the date signed. You may specify a lesser time here Date of expiration: \_\_\_\_\_. You may also revoke this authorization at any time by contacting DentaQuest's Customer Service Department 800.207.5019. If you cancel this permission DentaQuest will be unable to take back any information they may have shared previously.