Family Dentistry
OF BUDA

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____-_____-_____ Medical Record #:_____ Phone: _____

Address: _____City: _____State: _____Zip:_____

Date of Service: _____

☐ **I authorize** Dr._____ to use and disclose my protected health information for his/her own purposes of treatment, payment, and health care operations.

☐ **I authorize** Dr. _____ to disclose the following records related to the date above:

Records: □ All records □ Medical Records □ HIV/STD
□ Diagnostic Records (lab, x-ray, etc.) □ Drug and alcohol related
□ Treatment Records
□ Billing/Claims Records

Please release these records to:

Name: _____

Address: _____

City:_____ State:_____ Zip Code :_____

Phone: (____)_____Fax:_____ Email: _____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.
You may **revoke this authorization** in writing at any time by sending written notification to:
_____ Fax: _____
_____
_____

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.
You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on _____

_____ _____
Patient or Legal Representative Signature Date

_____
Print Patient or Legal Representative Name/Relationship