AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Requesting Office: ________________________ **Today's Date:** ________________
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RE: Patient: ____________________________ **Date of Birth:**____________________

I hereby authorize and request *Aesthetic General Dentistry of Frisco, PLLC* to furnish the listed items to:

REQUESTED ITEMS:____

SEND TO:____

_ I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immune deficiency virus (HIV). It may also include information about behavioral or mental health services, information concerning alcohol or drug abuse and social and family matters.

_A photostatic copy of this authorization is considered as effective as the original and will expire 180 days from date signed.

_This release form does not apply when a dentist or a hygienist of Aesthetic General Dentistry of Frisco, PLLC, share a record with other health care providers for the treatment purposes and transfer of records to dentists who are purchasing their practices.

_I understand I have the right to revoke this authorization at any time provided that the revocation is in writing. My refusal to sign this form does not affect my healthcare or the payment for my healthcare.

_ I understand that authorizing this disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_I understand that my refusal to sign this form does not affect my health care treatment or the payment of my healthcare treatment.

Signature of Patient or Patient Representative Below

____ __________________________

(If not the patient, please state your relationship to the patient) Date