Patient Authorization to Disclose Protected Health Information (PHI)

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

NAME OF PATIENT

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (*Optional*): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

☐ Implant Dentistry & Perio Rehab
Dr. William S. Neale, DDS., MD
2106-A Virginia Dr. Wichita Falls TX 76309 (940) 322-0758

☐ Other: Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

WHO CAN RECEIVE APPOINTMENT RELATED INFORMATION?

☐ SELF ONLY (PATIENT)
☐ OTHER: INDICATE RELATIONSHIP: _____

Other Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email Address: _____

Appointment Notifications / Reminders are to be received by means of: (check all that apply)

☐ Telephone Call ☐ Voicemail ☐ SMS / Text Message ☐ Mail ☐ Email

WHO CAN RECEIVE AND THE USE THE HEALTH INFORMATION?

☐ SELF (PATIENT)
☐ THIRD PARTY

Third Party Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Information is to be received by means of:

☐ Mail ☐ Fax ☐ Receive in Person ☐ USB Flash Drive ☐ Encrypted Email ☐ Other: _____

WHAT INFORMATION IS BEING DISCLOSED? (Processing Fees Apply for Duplication*)

☐ Dental Record from (insert date) _____ to (insert date) _____ or for condition described: _____

☐ Entire Dental Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

☐ Copy of Complete Dental Chart ☐ Copy of Dental X-Rays ☐ Other: _____

REASON FOR RELEASE OF INFORMATION (CHOOSE ALL THAT APPLY):

☐ Treatment/Continuing Medical Care ☐ Personal Use ☐ Billing or Claims ☐ Insurance ☐ Legal Purposes

☐ Disability Determination ☐ School ☐ Employment ☐ Other *(Specify)* _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on _____ (date supplied by patient; or _____ if revoked in writing by patient; or _____ 180 days from the date hereof; or _____ under the following conditions: _____..)

It is understood by Implant Dentistry and Perio Rehab that I authorize the release of my PHI by Implant Dentistry and Perio Rehab for the purposes of appointments, billing, marketing, and continuity of care. I understand that I may revoke my authorization for specific activities in writing to Implant Dentistry and Perio Rehab in accordance with the Notice provided.

Patient/Legal Representative: _____ Date: _____