FORT WORTH
pediatric
DENTISTRY

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Authorization to Release Health Care Information

Patient(s) name: _____ Date of birth: _____

Practice Name: FORT WORTH PEDIATRIC DENTISTRY, PLLC

I request and authorize the above listed dental practice to release health care information of the patient named above to:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Office email address: _____ Appointment Date: _____

This Authorization expires on: _____

Or: _____ Days After The Date It Is Signed, or When The Following Event Occurs:

_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

A Sign and date the form available from the doctor or practice called "Revocation of Authorization For Use And Disclosure of Health Care Information" or

B Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date

_____

Relationship or status if signed by parent, legal guardian or personal representative