Authorization for Use or Disclosure of Health Information

I, _____, hereby authorize **Helotes Cosmetic & Family Dentistry, PLLC** to either use the following health information or disclose the following information to:

Name And Address of Organization To Use or Receive Information:

_____

_____

_____

_____

Describe Information To Be Disclosed:
Describe the information to be used or disclosed, such as type of service provided, date of service, and level of detail to be released.

_____

_____

_____

Purpose Of Each Disclosure:

_____

_____

_____

Expiration Date: _____

This authorization shall be in force and effect until the above date, at which time it will expire. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Privacy Officer: Dr. Hien T. Nguyen

Office address: 7608 W. Military Drive
San Antonio, TX 78227

I understand that:

- A revocation does not affect health information already sent out under the Authorization.
- My treatment, payment, enrollment or benefits will not be based on whether I provide authorization for the requested use or disclosure.
- That there is potential for my Protected Health Information to be re-disclosed by the recipient.

_____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Personal Representative's Authority