ANDERSON ATKINS DDS
1700 Crescent Pointe Parkway
College Station, TX 77845
979.846.1813
info@andersonatkinsdds.com

Authorization for Release of Identifying Health Information

Patient Name: _____
Address: _____
Phone Number: _____

I authorize the office of Anderson & Atkins, DDS to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information released: Any dental related conditions, or possible health information, i.e. radiographs, periodontal charting, dental models, photos, or likeness.

2. To whom the information be released [name(s) or class(es) of recipients]: Insurance companies, dental specialists, or other health specialists.

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): To obtain payment from third party billing, to further medical and dental care necessitating the use of specialists.

4. Expiration date of event relating to the individual or purpose for the release: Upon written notification by patient or last visit in our office over twenty-four (24) months.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon authorization. If you want to revoke your authorization, send us a written or electronic note, instructing us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she chooses. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ACKNOWLEDGE I HAVE RECEIVED A COPY OF ANDERSON & ATKINS, DDS NOTICE OF PRIVACY PRACTICES.

Patient Signature: _____
Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____
Print Your Name: _____
Signature: _____