AUTHORIZATION FOR THE USE OR DISCLOSURE OR HEALTH INFORMATION

I, _____, hereby authorize Merrill W. Russell, DDS to either use the following health information or disclose the following information to:

Name and Address of Organization to Use or Receive Information

_____

_____

_____

Description of Information to be Disclosed (i.e.. types of treatment, dates of service, types of records, level of detail, etc.)

_____

_____

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: Merrill W Russell, DDS
2915 Medical Arts Street
Austin, TX 78705

alternate address:
16913 John Michael Drive
Manor, TX 78653

contact@austinalpinedental.com

I understand that a revocation does not affect health information already sent out under the Authorization, that my treatment, payment, enrollment or benefits will not be based on whether I provide authorization for the requested use or disclosure, and that there is a 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 Representative's Authority