

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 **alternate address:**
2915 Medical Arts Street **16913 John Michael Drive**
Austin, TX 78705 **Manor, TX 78653**
merrillrussell53@gmail.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