AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION ELECTRONICALLY

(Other than for Treatment, Payment or Health Care Operations)

Practice Name: **Phillip F Sehnert DDS PA**
Practice Address: **501 West Main Street, Lewisville, TX 75057**
Practice Phone: **972-420-0042**

Patient Name:	**Date of Birth**	**Verification of Identity (Driver's License, ID Card Passport, etc)**
Address:		Dental Record Number:

By signing this form, I Authorize **Dr Phillip F Sehnert** to disclose my protected health information
Via: ☐ **e-mail** ☐ Other Electronic Media (Describe) _____
☐ Audio Teleconference ☐ Video Teleconference

Complete the following only if e-mail correspondence is being authorized:

Patient's e-mail address:	***Caregiver's e-mail address:***

I understand that the following types of protected health information may be disclosed as a result of the electronic communication: (check all that are approved)

☐ My personal health information contained in my medical record
☐ Video or electronic diagnostic images, laboratory and diagnostic test results
☐ Video recordings or still pictures of parts of my body that may include my face

I further authorize the disclosure of the following information which may be included in the protected health information listed above: ***(check all that are approved)***

☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS

My signature on this Authorization indicates that I am giving permission for the uses and disclosures of the protected health information described above. I hereby release **Phillip F Sehnert DDS PA** and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that **Dr Phillip F Sehnert** will not condition treatment on my signing this authorization. Treatment will not be denied if I do not sign this form.

I understand that I may revoke this authorization at any time by submitting a written request.

This authorization expires automatically on: ☐ No expiration ☐ Other Date _____

I have read and understand the information in this authorization form	
Signature of Patient or Legal Representative	Date

Oral Authorization (for person physically unable to sign)
Not applicable to HIV related information or Drug & Alcohol treatment information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses required).

Witness #1 _____ Date: _____

Witness # 2 _____ Date: _____