AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION ELECTRONICALLY

Patient Authorization for Release of Health Records to External Parties

1. I authorize The office of **Phillip F Sehnert DDS PA,** located at 501 West Main Street in Lewisville, TX, 75057, Phone: 972-420-0042 to disclose information from the health records of:

   _____

   (patient)

   Date of Birth: _____

☐ **I authorize the information to be disclosed to** the following Entities:

Referring Drs, Specialists, Insurance Companies and Billing Entities

☐ I authorize this information to be disclosed in the following ways:
Written/Photocopy/Paper, Verbal, Fax, Electronic Mail (email), Filing Insurance electronically, Electronic Billing

☐ I understand that the following types of protected health information may be disclosed as a result of the electronic communication:

My personal health information contained in my dental record
Video or electronic diagnostic images and X-Rays
Video recordings or still pictures of parts of my body that may include my face

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Phillip F Sehnert DDS PA in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

This authorization does not expire unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)