Dr. Antonio Reyes, D.D.S.
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McKinney, TX 75069
Phone: 469-952-2712
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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I (patients name)_____, authorize the professional office of my dentist named above to release health information identifying me to carry out treatment, payment activities, and health care operations.

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.

Right to Revoke: 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 the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

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 wishes. 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.

Dated_____ Patient signature_____

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:

Print Name_____

Source of Authority_____

Revoke
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation.

Signature: _____
Only sign here if you want to decline, do not sign both places, thank you!
Date: _____

****In non "legal" language, this means we can only use your information to file your insurance, provide dental care to you, collect our fee and communicate with other health care providers that we have referred you to.**