

Authorization for Use or Disclosure of Health Information

I, _____, hereby authorize Sara A. Bender, DDS, MS, PA to either use the following health information or disclose the following information to: name and address of organization to use or receive information:

Dental Insurance Company Name: _____

Describe information to be enclosed , such as type of service provided, date of service, and level of detail to be released: 1) Dental /Periodontal information

2)Other(specify if applicable)_____

Purpose of each disclosure:1) Dental/medical insurance benefit coverage

2) Other_____

No Expiration Date unless specified:_____

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: Sara A. Bender, DDS, MS, PA
Office address: 3550 Parkwood Blvd., Ste. 308, Frisco, TX 75034

I understand that:

- A revocation does not effect health information already sent out under the Authorization.
- My treatment, payment, enrollment or benefits will not be based on whether I provide authorization for the requested use or disclosure.
- 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

Personal Representative's Authority