AUTHORIZATION FORM

Fred E. Hirt, DDS ("Covered Entity") is requesting the below named patient or his or her representative or legal guardian ("Patient"), to authorize the use and/or disclosure of certain Protected Health Information (as defined in 45 CFR 164.501) to a physician or other healthcare provider, to insurance companies and others to obtain payment for services we provide to the patient, for healthcare operations (including quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluating practitioners performance, conducting training programs), to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for you healthcare. We may disclose your health information to appropriate authorities if we reasonably believe that the patient is a possible victim or other crimes. We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). The Protected Health Information for which authorization is requested can be specifically describe as individually identifiable health information that is transmitted or maintained by electronic (or other) media. Authorization for the use and/or disclosure of such Protected Health Information is requested for purposes of examining, maintaining, improving or treating the patient's oral or general health.

CONDITIONS:

- The Patient or Legal Guardian agrees that the Covered Entity may disclose the Patient's confidential healthcare information to the above name individual/organization only for the purposes listed above.
- Once the information is released, the information may be subject to re-disclosure by the recipient and will not be protected under the privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996.
- The Covered Entity will provide the Patient or Legal Guardian with a copy of the confidential healthcare information for which this authorization is being sought upon the written request of the Patient.
- The Covered Entity may not condition treatment, payment, enrollment or eligibility for benefits (as applicable) on whether the Patient or Legal Guardian signs this authorization.
- The Patient or Legal Guardian is voluntarily signing this authorization.
- The Patient or Legal Guardian will receive a copy of the signed authorization upon his or her request.
- This authorization is in effect until the Patient or Legal Guardian revokes it. After that time, this authorization is automatically revoked and so further use or disclosure of the Patient's confidential healthcare information is permitted to the above-stated person or entity beyond that date.
- The Patient or Legal Guardian has the right to revoke this authorization at any time. This revocation must be in writing and submitted to the following address: Fred E. Hirt DDS, 711 W. Bay Area Blvd., Suite 604, Webster, Texas 77598.
- Once this authorization is revoked, the Covered Entity will not use or disclose the protected healthcare information for the above-stated purpose to the extent that the Covered Entity has already relied on the authorization.

SIGNATURES:

Patient/Legal Guardian: _____ Date: _____

If Legal Guardian, relationship to Patient: _____

Witness: _____ Date: _____