DENTISTRY
TEXAS A&M UNIVERSITY

PATIENT AUTHORIZATION TO USE OR DISCLOSE INFORMATION

I understand **TEXAS A&M UNIVERSITY COLLEGE OF DENTISTRY** is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization. I understand a fee may be assessed and required to be paid prior to any duplication of records and/or x-rays.

I specifically authorize **TEXAS A&M UNIVERSITY COLLEGE OF DENTISTRY** or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Patient Information is needed for:

☐ Continuing Dental Care ☐ Insurance ☐ Legal Purposes

☐ Personal Use ☐ School

☐ Other:_____

Description of the information to be used or disclosed *(check all that apply)*:

☐ X-Ray

☐ Dental Records

☐ Financial

☐ Other_____

Please disclose the above information to:

Name:_____ Telephone:_____

Address:_____

I ☐ do ☐ do not authorize this information to be faxed. If yes, Fax #:_____

I ☐ do ☐ do not authorize this information to be Emailed. If yes, to:_____

I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, TEXAS A&M UNIVERSITY COLLEGE OF DENTISTRY must receive the revocation in writing, and the revocation must include:

- My name and address,
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
- My desire to revoke this authorization, and
- The date of the revocation, and my signature.

TEXAS A&M UNIVERSITY COLLEGE OF DENTISTRY will accept written revocations of this authorization via:

☐ Certified U.S. mail to Office of Clinical Affairs, 3302 Gaston Avenue Suite 101, Dallas Texas 75246
☐ Facsimile at this number: 214-874-4552

ALL revocations must be sent to The Office of Clinical Affairs, and are not effective until received by him/her.

This authorization shall expire on_____. After this date, TEXAS A&M UNIVERSITY COLLEGE OF DENTISTRY can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____	_____
Signature of Patient or Patient's Representative	Date
_____	_____
Name of Patient	Patient date of birth
_____	_____
Name of Representative (if applicable)	Description of Representative's Authority to act for patient

FOR OFFICE USE ONLY
☐ Authorization added to the patient's record on _____.
☐ Authorization verified by _____ on _____.
☐ Patient has been provided with a copy of the signed authorization.