Children's Dentistry of Central Texas
Renicko Lindquist, D.D.S.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the practice of Renicko Lindquist, DDS. to disclose the following information from the health records of:

Patient's Name_____
Address_____
_____
Telephone_____

Information to be disclosed:

Complete health record(s)
History & physical examination
Consultation reports
X-ray reports
Progress notes
Discharge summary
Other_____

Purpose of Disclosed:

Treatment
Payment
Healthcare operations
Disclose protected health information to third party

This information will be disclosed to:

Name_____ Relationship_____
_____ _____
_____ _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 2 years from date signed.

This practice and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed_____ Date_____

Witnessed_____ Date_____