

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Dr. Jeff Zapalac, D.D.S., M.S. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Dr. Jeff Zapalac, D.D.S., M.S. to use or disclose to

General Dentist, Oral Surgeon, Invisalign, Ins. the
[Person or Entity to receive the information]

following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

Orthodontic records

This authorization will expire on end of treatment

[Expiration Date or Defined Event]

When my 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 the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Dr. Jeff Zapalac, D.D.S., M.S. has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Jeff Zapalac, D.D.S., M.S.'s Privacy Officer at 5656 Bee Cave Road C-100, Austin, Texas 78746.

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian