James L. Doyle DDS
4507 Sweetwater Blvd.
Sugar Land, TX 77479
281-980-1150

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I hereby authorize the above named dentist to use or disclose the specific information described below, only for the purposes and parties also described below.

Detailed description of the information to be released:

- X-rays, Intra-oral photos, Detailed narratives of dental information, Insurance information, Medical history

To whom may the information be released:

- Insurance Companies, Healthcare providers

I authorize you to share my information with:

( ) Myself only ( ) Spouse ( ) Adult Children ( ) Parents

This information is being requested for the following purposes:

Insurance authorization
Referring to other healthcare providers
Fee collection
Filing insurance claims

This authorization shall remain in effect from the date signed below until further notice of written withdrawal.
I understand that:

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office, attention Privacy officer.

Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and no longer protected by HIPAA.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature_____ Dated_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____