H-E-B Family Dentistry
Patient's Representative Authorization

In accordance with new federal regulations we are not allowed to discuss or even acknowledge that you are a patient of H-E-B Family Dentistry without your expressed written consent. If there is anyone (i.e... spouse, parent, neighbor, etc.) you think might ever have a need to discuss your dental treatment, appointments, or your financial account please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to your representative.

□ Discussion of financial account □ Discussion of dental records
□ Discussion of scheduling appointments □ Other_____

Select one of the following:

□ This authorization will expire on the following date: _____

□ This authorization will expire when dental treatment has been finished and all financial matters are settled.

I understand that I may revoke this authorization at any time by giving written notice to the front desk staff. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

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1) Personal Representative's Name:_____
Relationship to patient: _____

2) Additional Representative's Name: _____
Relationship to patient:_____

Patient's Name: _____ Date of Birth:_____
Telephone: _____ Alt Telephone:_____

Patient's Signature:_____ Date:_____
(or patient guardian/representative signature if patient is under the age of 18 years old)