Dr. Antonio Reyes, D.D.S.
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McKinney, TX 75069
Phone: 469-952-2712
Fax: 469-952-2714

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment as well as follow up among the multiple healthcare providers (if applicable) who may be involved in my treatment directly and indirectly.
- Obtain payment from insurance companies and/or third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given a copy of your Notice of Privacy Practices with my paperwork containing a more complete description of the uses and disclosures of my health information. I have been given the time and opportunity to read your Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that Eldorado Dental has the right to change its Notice of Privacy Practices and that I may contact them at any time to obtain a current copy.

By signing you certify that you have received and read Eldorado Dental's Notice of Privacy Practices.

Signature: _____ Date: _____
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:

Print Name_____

Source of Authority (parent/guardian/ect.)_____

*****In non "legal" language, this means we will only use your information to file your insurance, provide dental care to you, collect our fee and communicate with other health care providers that we have referred you to.*****

Cancellation and No Show Policy

To avoid last minute cancellations and no shows, please acknowledge Eldorado Dental's cancellation policy. **If you need to reschedule or cancel, we ask you to give us a 24 hour notice to avoid a fee of $50.00.** The Dr. sets aside a certain amount of time just for your visit, and to give you his personal attention. No shows and last minute cancellations cause lost time on his part that he could be using to help another patient. **Please give us the courtesy of 24 hours to reschedule or cancel to avoid charges.**

Thank you,

Eldorado Dental
Kim Reyes
Office Manager

I have read the above and agree:
Signature of patient, parent, or guardian: _____
Date: _____
Relationship to Patient: _____