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**Authorization to Disclose Protected Health Information
To Another Individual, Parent, or Legal Guardian.**

By signing this authorization, I authorize Cindy Brayer, DMD & Bao Nguyen, DDS to use/or disclose protected health information (PHI) about me to:

1. _____ DOB: ____/____/____

2. _____ DOB: ____/____/____

3. _____ DOB: ____/____/____

By checking this box I do not want anyone to receive my personal health information.

This authorization permits Dr. Cindy Brayer and Dr. Bao Nguyen to disclose individual, identifiable dental information about me without limitations to the above named person(s). The information will be used or disclosed for the following purpose: To transmit/translate medical information and instructions.

I do not have to sign this authorization in order to receive treatment from Dr. Cindy Brayer or Dr. Bao Nguyen. In fact, I have the right to refuse the signing of this authorization.

When my information is used or disclosed to an individual in pursuant to this authorization, my information may be subject to disclosure by that recipient and may no longer be protected by the federal HIPPA Privacy Rule. This authorization will continue until I revoke it.

I have the right to revoke this authorization, in writing, except to the extent that the practice has acted in reliance on this authorization. My written revocation must be dated, signed and submitted to Cindy Brayer, DMD, PA and Bao V. Nguyen, DDS, PA at 3388 49th Street North, St. Petersburg, FL 33710 to remove an individual.

Signed: _____
(Patient or Legal Guardian) (Relationship to Patient)

Please Print Name Legibly: _____

DOB: ____/____/____ Social Security Number: _____