AN AGREEMENT BETWEEN COLLIN COUNTY HEALTH CARE FOUNDATION AND DENTAL HEALTH PROGRAMS, INC.

This agreement, made October 1, 2009 by and between the Collin County Health Care Foundation, 825 N. McDonald Street, McKinney, Texas 75069 and Dental Health Programs, Inc. (FIN 75-1823660) d/b/a Community Dental Care, 1420 West Mockingbird Lane, Suite 500, Dallas, TX 75247.

Whereas, Collin County Health Care Foundation, hereinafter referred to as "CCHCF", wishes to purchase dental health services for the most vulnerable United States citizens and legal residents of Collin County; and

Whereas, Dental Health Programs, Inc, hereinafter referred to as "Provider" has been providing routine dental care to low income individuals at clinical space provided at no cost by CCHCF in Plano, Texas and McKinney, Texas.

NOW THEREFORE, this agreement is made and entered into by the Collin County Health Care Foundation and Dental Health Programs, Inc.

1. **Term of Agreement.** This agreement shall be effective as of October 1, 2009 and ends on September 30, 2010.

2. **Scope of Work.** The "Provider" shall provide dental health screenings and treatment to qualified, low-income, uninsured U.S. citizens and legal residents of Collin County, Texas in clinic space provided by CCHCF in Plano and McKinney, Texas. The Provider shall perform the following during the term of this agreement:

    a. Provider is required to use due diligence in determining patient eligibility as condition of payment from CCHCF. Patients eligible for payment under this Agreement are those individuals who are U.S. Citizens and legal residents residing and domiciled in Collin County, Texas, and of limited means and financial resources to pay for dental health care services provided by Provider.
    b. Provider will ensure that patients referred directly by Collin County Health Care Services receive timely appointments.
    c. Provider will provide up to 300 dental visits to low income senior citizens (over the age of 55 years) whose family income is below 100% of the Federal Poverty Level, are U.S. citizens and legal residents of Collin County, Texas and are uninsured.
    d. Provider will provide up to 100 dental visits to adults who are determined eligible for the Collin County Indigent Health Care Program. No co-payment is allowed for indigent clients.

e. Provider will provide up to 100 dental visits to uninsured children (under 18 years of age), whose family income is below 100% of the Federal Poverty Level, are U.S. citizens and legal residents of Collin County, Texas and do not qualify for Medicaid or SCHIP.
f. Provider will be paid on a fee-for-service basis of $80.00 per patient visit. Patients must be domiciled and reside in Collin County, Texas.
g. Payment from CCHCF to Provider shall be contingent upon the completion of the invoice in the format provided and attached as Exhibit "A". (See Exhibit "A"). All data fields contained in exhibit "A" must be completed in electronic format and submitted to CCHCF before any payment will be paid to Provider. CCHCF reserves the right to reject any claim for payment for incomplete or unverifiable data submitted by Provider.
h. CCHCF will only pay for dental visits between October 1, 2009 and September 30, 2010.
i. A prearranged site visit may be conducted on behalf of the CCHCF by the Manager, Collin County Health Care Services, her designee or the Collin County Auditors Office. CCHCF reserves the right to audit records for financial accuracy and contractual compliance for any and all claims made for payment for services rendered under this contract.
j. Any revision to this scope of work, including the use of funds, must be mutually approved in writing prior to the implementation of the revision, by both the Manager of the Collin County Health Care Services and Provider.

3. **Payment of Services.** The total amount of this agreement shall not exceed $40,000. Provider shall submit all invoices in an electronic, Microsoft Excel format on a quarterly basis. The payment will be on an after-the-fact, fee-for-service basis. No more than $80.00 will be paid for each dental visit.

i. The first invoice shall be submitted no later than January 31, 2010 for the period October 1, 2009 - December 31, 2009.
ii. The second invoice shall be submitted no later than April 30, 2010 for the period January 1, 2010 – March 31, 2010.
iii. The third invoice shall be submitted no later than July 31, 2010 for the period April 1, 2010 – June 30, 2010.
iv. The final invoice shall be submitted not later than October 20, 2010 for the period July 1, 2010 – September 30, 2010.

The Collin County Health Care Foundation reserves the right to adjust the payments based on incomplete or unverifiable data. Invoices shall be submitted in a Microsoft Excel format by e-mail to Patsy Morris, Coordinator for Collin County Health Care Services at pmorris@co.collin.tx.us or by disk to Patsy Morris, Collin County Health Care Services, 825 N. McDonald St, McKinney, Texas, 75069.

4. **Indemnification.** To the extent allowed by law, each party agrees to release, defend, indemnify, and hold harmless the other (and its officers, agents, and

employees) from and against all claims or causes of action for injuries (including death), property damages (including loss of use), and any other losses, demands, suits, judgments and costs, including reasonable attorneys' fees and expenses, in any way arising out of, related to, or resulting from performance under this agreement, or caused by its negligent acts or omissions (or those of its respective officers, agents, employees, or any other third parties for whom it is legally responsible) in connection with performing this agreement. Provider expressly agrees to indemnify and defend CCHCF for any medical malpractice claim, or related claim, brought against Provider in which CCHCF is made a party.

5. **Provider Licensure and Insurance.** Provider warrants that it is in legal compliance with all State and Federal Medical licensure requirements. Provider is licensed to provide Medical care. Provider agrees to notify CCHCF of any suspension, revocation, or disciplinary action by any State or Federal Licensing body related to Provider's ability to provide health care. Provider has a current malpractice insurance policy which covers the services contemplated by this agreement.

6. **Venue.** The laws of the State of Texas shall govern the interpretation, validity, performance and enforcement of this agreement. The parties agree that this agreement is performable in Collin County, Texas and that exclusive venue shall lie in Collin County, Texas.

7. **Confidentiality of Protected Health Information.** Provider is required to comply with state and federal laws relating to the privacy and confidentiality of patient and client records that contain protected health information, or other health information made confidential by law.

   Provider agrees to provide certain basic data and information to CCHCF. This data and information is the same data and information requested for Exhibit "A". Provider agrees that CCHCF is authorized to request, collect and receive protected health information under this agreement. Provider agrees to have each client or legal guardian of the client treated under this agreement to sign the attached HIPAA release form, attached as Exhibit "B". This data may be used by CCHCF, but is not limited to, verify contractual compliance, statistical research, health research and awareness.

   As further condition for transmitting the data and information subject to this agreement, Provider agrees to execute the attached Business Associate Agreement. Attached as Exhibit "C".

8. **Successors and Assigns.** This agreement shall be binding upon parties hereto, their successor, heirs, personal representatives and assigns. Neither party will assign or transfer an interest in this agreement without the written consent of the other party.

9. **Severability.** The provisions of this agreement are severable. If any paragraph, section, subdivision, sentence, clause, or phrase of this agreement is for any reason held by court of competent jurisdiction to be contrary to law or contrary to any rule or regulation having the force and effect of the law, the remaining portions of the agreement shall be enforced as if the invalid provisions have never been included.

10. **Entire Agreement.** This agreement embodies the entire agreement between the parties and may only be modified in writing executed by both parties.

11. **Immunity.** It is expressly understood and agreed that, in the execution of this agreement, neither party waives, nor shall be deemed hereby to have waived any immunity or defense that would otherwise be available to it against claims arising in the exercise of governmental powers and functions. By entering into this agreement, the parties do not create any obligations, express or implied, other than those set forth herein, and this agreement shall not create any rights in parties not signatories hereto.

12. **Termination.** This agreement may be terminated by either party for any reason after thirty (30) days written notice. The written notice shall be sent to the addresses identified in the first paragraph of this Agreement. Provider shall be paid for all services provided up to the effective date of termination upon proper proof and submission of all required documentation.

Dental Health Programs, Inc.

By: Paul R. Hoffman
Name: Paul R. Hoffman
Title: Executive Director
Date: 8/31/09

Collin County Health Care Foundation

By: Keith A. Self
Name: Keith Self
Title: President
Date: 9/29/09

Exhibit C
Collin County Health Care Foundation
Business Associate Contract
in accordance with
the Health Insurance Portability and Accountability Act
And Incorporated Security Addendum

This Agreement is entered into by and between Collin County Health Care Foundation ("CCHCF" and "Business Associate") and Dental Health Programs, Inc. ("Provider") and is intended to be effective as of the 1st day of October, 2009 ("Effective Date").

WITNESSETH:

WHEREAS, CCHCF, as an entity involved in providing Health Care to the citizens of Collin County, Texas, and is a payor of medical services for individuals living in Collin County, Texas, and desires to become a Business Associate of Provider who is a treating physician, medical clinic, medical facility, or similar entity which provides health care services, treatment, or goods to individuals residing in Collin County, Texas; and

WHEREAS, CCHCF, as an entity involved in providing Health Care to the citizens of Collin, County, Texas, and is a payor of medical services, has a duty to ensure proper use of all funds extended to Provider for treating citizens of Collin County, Texas, and CCHCF participates in studies and research to aid in health care treatment and awareness of the citizens of Collin County, Texas, and therefore has a need to review certain data and information associated with medical services being paid to and provided by Provider; and

WHEREAS, Provider will make available and/or transfer to CCHCF certain data and information which may be Protected Health Information, in conjunction with goods, services, and treatment that are being provided by Provider to an individual whose medical treatment is paid by CCHCF, and therefore such data and information that is confidential must be afforded special treatment and protection; and

WHEREAS, CCHCF will have access to and/or receive from Provider certain Protected Health Information that can be used or disclosed only in accordance with this Contract and the HHS Privacy Regulations; and

WHEREAS, CHHCF and Provider hereby agree to comply in all of their business transactions with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the "CFR"). In the event of conflicting terms or conditions in any other written or oral agreement entered by the parties, the terms of this Agreement shall govern.

NOW, THEREFORE, CCHCF and Provider agree as follows:

1. **Definitions**. The following terms shall have the meaning ascribed to them in this Section. Other capitalized terms shall have the meaning ascribed to them in the context in which they first appear.

   a. "Contract" shall refer to this document.

   b. BUSINESS ASSOCIATE" shall mean Collin County Health Care Foundation also referred to as CCHCF.

   c. "CCHCF" shall mean the COLLIN COUNTY HEALTH CARE FOUNDATION, a Business Associate under this Agreement.

   d. "Health Care Operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, are listed in the definition of "health care operations" at 45 CFR 164.501.

   e. "HHS Privacy Regulations" shall mean the Code of Federal Regulations ("C.F.R.") at Title 45, Sections 160 and 164.

   f. "Individual" shall mean the person who is the subject of the Protected Health Information, and has the same meaning as the term "individual" is defined by 45 C.F.R. 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

   g. "Protected Health Information" shall have the same meaning as the term protected health "Protected Health Information" in 45 CFR 164.501, limited to the Protected Health Information created or received by Business Associate from or on behalf of CCHCF..

   h. "Required by Law" shall have the same meaning as the term has in 45 CRT 164.501.

   i. "Parties" shall mean Dental Health Programs, Inc. (Provider) and Collin County Health Care Foundation (BUSINESS ASSOCIATE and CCHCF).

   j. "Secretary" shall mean the Secretary of the Department of Health and Human Services ("HHS") and any other officer or employee of HHS to whom the authority involved has been delegated.

2. **Term**. The term of this Agreement shall commence as of the Effective Date, and shall expire when all of the Protected Health Information provided by Provider to

Business Associate is destroyed, deleted from data indices, or returned to Provider pursuant to clause 7(i) .

3. **Renewal Terms**. This Agreement may be renewed for additional terms following the expiration of the Term, by a writing executed by the Parties setting forth such renewal terms.

4. **Limits on Use and Disclosure Established by Terms of Contract**. CCHCF hereby agrees that it shall be prohibited from using or disclosing the Protected Health Information provided or made available by Provider for any purpose other than as expressly permitted by this Contract or as required by law. (ref. 164.504(e)(2)(i).)

5. **Stated Purposes for which CCHCF May Use or Disclose Protected Health Information**. The Parties hereby agree that CCHCF shall be permitted to use and/or disclose Protected Health Information provided or made available from Provider for the following stated purposes:

> CCHCF shall be entitled to access and or use the minimum necessary Protected Health Information as is necessary for CCHCF to carry out its duties to ensure that CCHCF funds are used as stated in the attached and incorporated Collin County Health Care Foundation Agreement with the Provider for the provision of prescription assistance to low income, uninsured United State's citizens and legal residents residing and domiciled in Collin County, Texas, and further to use such data and information to participate in studies and research for the benefit of health care and awareness to the benefit of the citizens of the United States, Texas, and Collin County, Texas. **(ref. 164.504(e)(2)(i); 65 Fed. Reg. 82505.)**

6. **Additional Purposes For Which CCHCF May Use Or Disclose Protected Health Information**. In addition to the Stated Purposes for which CCHCF may use or disclose Protected Health Information described in clause 5, CCHCF may use or disclose Protected Health Information provided or made available from Provider for the following additional purpose(s):

   a. **Use of Protected Health Information for Management, Administration and Legal Responsibilities**. CCHCF is permitted to use Protected Health Information if necessary for the proper management and administration of CCHCF or to carry out legal responsibilities of CCHCF. (ref. 164.504 (e)(4)(i)(A-B))

   b. **Disclosure of Protected Health Information For Management, Administration and Legal Responsibilities**. CCHCF is permitted to

disclose Protected Health Information received from Provider for the proper management and administration of CCHCF or to carry out legal responsibilities of CCHCF, provided:

i. The disclosure is required by law; or

ii. That CCHCF obtains reasonable assurances from the person to whom the Protected Health Information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the Protected Health Information, and the person immediately notifies the CCHCF of any instance of which it is aware in which the confidentiality of the Protected Health Information has been breached. (ref. 164.504(e)(4)(ii).

c. **Data Aggregation Services**. CCHCF is also permitted to use or disclose Protected Health Information to provide data aggregation services, as that term is defined by 45 C.F.R. 164.501, relating to the health care operations of Provider or CCHCF. (ref.164.504(e)(2)(i)(B))

7. **CCHCF OBLIGATIONS**:

a. **Limits on Use and Further Disclosure Established by Contract and Law**. CCHCF hereby agrees that the Protected Health Information provided or made available by Provider shall not be further used or disclosed other than is permitted or required by the Contract or as required by law. (ref. 45 C.F.R. 164.504(e)(2)(ii)(A))

b. **Appropriate Safeguards**. CCHCF will establish and maintain appropriate safeguards to prevent any use or disclosure of the Protected Health Information, other than as provided for by this Contract. (ref. 164.504(e)(2)(ii)(B))

c. **Reports of Improper Use or Disclosure**. CCHCF hereby agrees that it shall report to Provider **within two (2) days of discovery** any use or disclosure of Protected Health Information not provided for or allowed by this Contract. (ref. 164.504(e)(2)(ii)(C)

d. **Subcontractors and Agents**. CCHCF hereby agrees that anytime Protected Health Information is provided or made available to any subcontractors or agents, CCHCF must enter into a subcontract with the subcontractor or agent that contains the same terms, conditions and

restriction on the use and disclosure of Protected Health Information as contained in this Contract. (ref. 164.504(e)(2)(ii)(D))

e. **Right of Access to Protected Health Information**. CCHCF hereby agrees to make available and provide a right of access to Protected Health Information by an Individual. This right of access shall conform with and meet all of the requirements of 45 C.F.R. 164.524, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(E))

f. **Amendment and Incorporation of Amendments**. CCHCF agrees to make available Protected Health Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(F))

g. **Provide Accounting**. CCHCF agrees to make Protected Health Information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528, including substitution of the words "CCHCF" with BUSINESS ASSOCIATE where appropriate. (ref. 164.504(e)(2)(ii)(G))

h. **Access to Books and Records**. CCHCF hereby agrees to make its internal practices, books, and records relating to the use or disclosure of Protected Health Information received from, or created or received by Provider available to the Secretary or the Secretary's designee for the purposes of determining compliance with the HHS Privacy Regulations. (ref. 164.504(e)(2)(ii)(H))

i. **Return or Destruction of Protected Health Information**. At termination of this Contract, CCHCF hereby agrees to return, delete from its indices, or destroy all Protected Health Information received from, or created or received by CCHCF from Provider. CCHCF agrees not to retain any copies of the Protected Health Information after termination of this Contract. If return or destruction of the Protected Health Information is not feasible, CCHCF agrees to extend the protections of this Contract for as long as necessary to protect the Protected Health Information and to limit any further use or disclosure. If CCHCF elects to destroy or delete from its indices the Protected Health Information, it shall certify to Provider that the Protected Health Information has been destroyed. (ref. 164.504(e)(2)(ii)(I))

j. **Mitigation Procedures**. CCHCF agrees to have procedures in place for mitigating, to the maximum extent practicable, any deleterious effect from

the use or disclosure of Protected Health Information in a manner contrary to this Contract or the HHS Privacy Regulations. (ref. 164.530(f))

CCHCF agrees and understands that it must develop and implement a system of sanctions for any employee, subcontractor or agent who violates this Agreement or the HHS Privacy Regulations. (164.530(e)(1))

8. **Obligations of Business Associate**

Provisions for Business Associate to Inform Provider of Privacy Practices and Restrictions:

a. Business Associate shall notify Provider of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associates use or disclosure of Protected Health Information.

b. Business Associate shall notify Provider of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associates use or disclosure of Protected Health Information.

c. Business Associate shall notify Provider of any restriction to the use or disclosure of Protected Health Information that Business Associate has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associates use or disclosure of Protected Health Information.

9. **Property Rights**. The Protected Health Information shall be and remain the property of Provider. CCHCF agrees that it acquires no title or rights to the Protected Health Information, including any de-identified Protected Health Information, as a result of this Contract.

10. **Termination of Contract**. Both parties agree that either party has the right to immediately terminate this Contract and seek relief under the Disputes Article if either party determines that either party has violated a material term of this Contract. (ref. 164.506(e)(2)(iii))

11. **Grounds for Breach**. Any non compliance by Business Associate with this contract or the HHS Privacy Regulations will automatically be considered grounds for Breach, if Business Associate knew or reasonably should have known of such non-compliance and failed to immediately take reasonable steps to cure the non compliance.

12. **Choice of Law**. This Contract shall be governed by the law of the State of Texas. The Parties also agree that for purposes of privacy rights, the HHS Privacy Regulation shall supercede all applicable state laws.

13. **Disputes**. Any controversy or claim arising out of or relating to the contract will be finally settled by compulsory arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"), except for injunctive relief as described below in article or in court of competent jurisdiction.

14. **Injunctive Relief**. Notwithstanding any rights or remedies provided for in this Contract, Provider retains all rights to seek injunctive relief in a court of competent jurisdiction to prevent or stop the unauthorized use or disclosure of Protected Health Information by CCHCF or any agent, contractor or third party that received Protected Health Information from CCHCF.

MISCELLANEOUS:

15. **Binding Nature and Assignment**. This Contract shall be binding on the Parties hereto and their successors and assigns, but neither Party may assign this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

16. **Notices**. Whenever under this Contract one party is required to give notice to the other, such notice shall be deemed given if mailed by First Class United States Mail, postage prepaid, and addressed as follows:

CCHCF:

Patsy Morris
Collin County Health Care Services
825 N. McDonald Street, Suite 130
McKinney, TX 75069

Provider:

Dental Health Programs, Inc.
1420 West Mockingbird Lane, Suite 500
Dallas, Texas 75247

Either Party may at any time change its address for notification purposes by mailing a notice stating the change and setting forth the new address.

17. **Good Faith**. The Parties agree to exercise good faith in the performance of this Contract.

18. **Article Headings**. The article headings used are for reference and convenience only, and shall not enter into the interpretation of this Contract.

19. **Force Majeure**. Business Associate shall be excused from performance under this Contract for any period Business Associate is prevented from performing any services pursuant hereto, in whole or in part, as a result of an Act of God, war, civil disturbance, court order, labor dispute or other cause beyond its reasonable control, and such nonperformance shall not be grounds for termination.

20. **Attorney's fees**. Except as otherwise specified in this Contract, if any legal action or other proceeding is brought for the enforcement of this Contract, or because of an alleged dispute, breach, default, misrepresentation, or injunctive action, in connection with any of the provisions of this Contract, each party shall bear their own legal expenses and the other cost incurred in that action or proceeding.

21. **Entire Agreement**. This Contract consists of this document, and constitutes the entire agreement between the Parties. There are no understandings or agreements relating to this Agreement which are not fully expressed in this Contract and not change, waiver or discharge of obligations arising under this Contract shall be valid unless in writing and executed by the Party against whom such change, waiver or discharge is sought to be enforced.

22. **Security Addendum**. Pursuant to the requirements of the Security Regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 ("Security Rule") found at 45 CFR Part 164. The Provider and CCHCF agree to assume the following obligations regarding electronic Protected Health Information (e-PHI):

    a. CCHCF and Provider agree to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the e-PHI that it creates, receives, maintains or transmits.

    b. CCHCF and Provider will ensure that any agent, including a subcontractor, to whom it provides e-PHI that was created, received, maintained or transmitted agrees to implement reasonable and appropriate safeguards to protect the confidentiality, security, and integrity of e-PHI.

    c. CCHCF and Provider agree to alert the other party of any security incident (as defined by the HIPAA Security Rule) of which it becomes aware, and the steps it has taken to mitigate any potential security compromise that may have occurred, and provide a report of any loss of data or other information system compromise as a result of the incident.

    d. CCHCF and Provider agree to termination of the BA Agreement if either party reasonably determines that either party has violated a material term of this Amendment.

IN WITNESS WHEREOF, Provider and CCHCF have caused this Contract to be signed and delivered by their duly authorized representatives, as of the date set forth above.

Dental Health Programs, Inc. ("Provider")
By: _____
Print Name:
Title: Executive Director

Collin County Health Care Foundation("CCHCF and Business Associate")
By: _____
Print Name: Keith Self
Title: President of CCHCF

Exhibit B
DENTAL HEALTH PROGRAMS, INC.

CASE INFORMATION RELEASE

Case Name: _____ **Case Number:** _____

By signing this authorization form, you are giving the Dental Health Programs, Inc. consent, authorization, and permission to release and discuss part of your case record (hereinafter collectively referred to as "Records") , which may also include personal health information. I authorize Dental Health Programs, Inc. to release my Record(s) to the person(s) or agencies listed below for the purpose(s) stated below. My information will remain available to the person(s) or agencies indicated until the expiration date stated below.

Consent and Authorization for Release of information: I understand that my Record(s) may contain protected health information (PHI), in addition to treatment, payment, health care operation, personal financial, and transportation information. I hereby consent to and authorize communication about my Records between agents and employees of Dental Health Programs, Inc., and Collin County Health Care Foundation (CCHCF).

Check one of the following:

☐ Release all of my case record.

☐ Release only the following information:
Full Name, Date of Service, Address, Date of Birth (Age), Sex, Last Four Digits of Social Security Number, Copy of Birth Certificate, Client Category (Child, Indigent, Senior) and New or Returning Patient.

Purpose(s) of this Consent, Authorization, and Release: This consent, authorization, and release of information is to help CCHCF determine whether I qualify for financial assistance for healthcare services that may be provided to me by Dental Health Programs, Inc.. This consent, authorization, and release of information may also be used to assist CCHCF to participate in research and studies for health care and awareness.

Expiration of Authorization: This authorization expires in 365 days from today's date or until my eligibility for services can be determined, whichever occurs first.

Notice to Client/Applicant

- By signing this release, consent, and authorization, I acknowledge that the information used or disclosed pursuant to this release and authorization may be subject to re-disclosure by the persons, entities, or agencies whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. CCHCF is not responsible for any re-disclosure of the information by others who may receive it.
- Client/Applicant may revoke this permission and cancel this release, consent and authorization at any time. Any request for cancellation must be in writing and delivered to CCHCF attn: Patsy Morris, Collin County Health Care Services, 825 N. McDonald St. McKinney, TX 75069.
- This release, consent, and authorization is a mandatory condition for payment of the health care services by CCHCF. However, you have a right to pay for your own services and not sign this document.
- You may receive a copy of any information obtained by CCHCF and Dental Health Programs, Inc. about you. You have the right to review such information and request that any information obtained in error or any information that is incorrect be corrected.

Signatures:

_____ _____
(Client/Applicant or Personal Representative's Signature) Date

☐ If you are signing for the client/applicant, please describe your authority to act for the client/applicant on the following line:

_____

Note: If the person requesting the release of case information cannot sign her/her name, two witnesses to his/her mark (X) must sign below:

Witness: _____ Date: _____

Witness: _____ Date: _____