Authorization for Release of Information – Compound Release

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

|  |  |
| --- | --- |
|  |  |
| **CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.** | **CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.** |
| * Voice Mail
 | * Results of lab tests/x-rays
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other person (s) (provide name and phone number)
 | * Financial
* Medical
 |
| * Email communication-Provide email address\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*For email communication to occur, please accept the disclosure below: | * Financial
* Medical
* Appointment reminders
* Breach notification
 |
| * Text communication – Provide number \* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*For text communication to occur, accept the disclosure below: | * Appointment reminder
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.
 |
| * Photo of patient received by patient or legal guardian
* Photo taken by staff (Example: pre/post procedure)
* Other:
 | * May be posted in office
* May be posted on website
* Other:
 |

##### Patient’s Rights:

* I have the right to revoke this authorization at any time by contacting this office.
* I may inspect or copy the protected health information to be disclosed as described in this document.
* Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
* Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
* I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing*.*

## This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: Date:

\*Description of Personal Representative’s Authority (attach necessary documentation)

* Revoked by patient or personal representative on .

**DATE**

How revoked: 🞎 orally (in person or via phone) 🞎 in writing (place copy in patient’s file)