Authorization to Release Health Information – Compound Release



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| 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(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: | |
| * \* **Acknowledge 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 at the office * May be posted on website * Other: | |

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| **Patient’s Rights**: I have the right to revoke this authorization at any time in person or in writing.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.  * I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse. |

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

Signature of Patient or Personal Representative: Date:

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

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| REVOKED  How: 🞎 in person on . (date) If in person, signature is required.  Signature of Patient or Personal Representative:  🞎 in writing (place copy in patient’s file) |