



## Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____	
Riverwalk Smile Dentistry is authorized to release protected health information about the above named patient in the following manner to identified persons.	
<b>Entity to Receive Information</b> Check each person/entity that you approve to receive information	<b>Description of information to be released</b> Check each that can be given to person/entity on the left in the same section
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Other person(s) (provide name and phone number)(i.e. Spouse, Parent, Friend, Stepparent, Grandparent etc) <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Financial
<input type="checkbox"/> Email communication-Provide email address*	<input type="checkbox"/> Financial <input type="checkbox"/> Treatment/Treatment Plans <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
*For email communication to occur, please accept the disclosure below	
<input type="checkbox"/> Text communication-Provide number* _____	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other _____
*For text communication to occur, please accept the disclosure below	
<input type="checkbox"/> For email and/or text communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected	
<input type="checkbox"/> Photo of patient received by patient or legal guardian Spouse, Parent, Friend, Stepparent, Grandparent etc)	<input type="checkbox"/> May be posted in office/on website
<input type="checkbox"/> Photo taken by staff (example: pre/post procedure)	<input type="checkbox"/> Other _____
<b>Patient Rights:</b> <ul style="list-style-type: none"> <li>I have the right to revoke this authorization any time.</li> <li>I may inspect or copy the protected health information to be disclosed as described in this document.</li> <li>Revocation is not effective in cases where information has already been disclosed but will be effective going forward.</li> <li>Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.</li> <li>I have right to refuse to sign this authorization and that my treatment will not be conditioned on signing.</li> </ul>	
This authorization will remain in effect until revoked by the patient Signature of patient or representative _____ Date: _____	
*Description of representative's authority (attach necessary documentation)	