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.

Entity to Receive Information Check each person/entity that you approve to receive information	Description of information to be released Check each that can be given to person/entity on the left in the same section
☐ Voice Mail	☐ Appointment Reminders
☐ Other person(s) (provide name and phone number)(i.e. Spouse, Parent, Friend, Stepparent, Grandparent etc) ☐ _____ ☐ _____	☐ Financial
☐ Email communication-Provide email address* *For email communication to occur, please accept the disclosure below	☐ Financial ☐ Treatment/Treatment Plans ☐ Appointment reminders ☐ Breach notification
☐ Text communication-Provide number* _____ *For text communication to occur, please accept the disclosure below	☐ Appointment reminder ☐ Other_____
☐ 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	
☐ Photo of patient received by patient or legal guardian Spouse, Parent, Friend, Stepparent, Grandparent etc) ☐ Photo taken by staff (example: pre/post procedure)	☐ May be posted in office/on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where 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 re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have 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 representative_____ Date:_____

*Description of representative's authority (attach necessary documentation)