

Ferrell Family Dentistry

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Ferrell Family Dentistry is authorized to release protected health information about the above named patient in the following manner and 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.
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<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Appointment Reminders
<input type="checkbox"/> Other person (s) (provide name)(i.e. Spouse, Stepparent, Grandparent, Relative, Friend etc)	<input type="checkbox"/> Financial <input type="checkbox"/> Treatment
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	

<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Treatment <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
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<input type="checkbox"/> Photo of patient received by patient or legal guardian	<input type="checkbox"/> May be posted in office
<input type="checkbox"/> Photo taken by staff (Example: pre/post procedure)	<input type="checkbox"/> May be posted on website
<input type="checkbox"/> Other	<input type="checkbox"/> Other _____

Patient Rights:

- I have the right to revoke this authorization at 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 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)