

## Authorization for Release of Information – Compound Release

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

**Endodontic Specialists** \_\_\_\_\_ is authorized to release protected health information about the above named patient in the following manner and 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"/> Results of lab tests/x-rays Other _____
<input type="checkbox"/> Spouse (provide name and phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Parent (provide name and phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Breach notification
*In order for email communication to occur, please accept the disclosure below:	
<input type="checkbox"/> For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	
<input type="checkbox"/> Communication about treatment alternatives even if this office is being compensated for making the communication.	

**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.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

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