Authorization to Release Health Information – Compound Release

Name of Patient: _____ Date of Birth:_____

Enhanced Smiles _____ 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:_____	

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)

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)