Authorization for Release of Information - COMPOUND

Name of Patient _____ Date of Birth _____

Adkins 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.
Your Phone Number: _____ ☐ Voice Mail	☐ Results of test ☐ Dental Appointments or Treatment ☐ Financial
☐ Other person (s) (provide name and phone number)	☐ Results of test ☐ Dental Appointments or Treatment ☐ Financial
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical/Dental ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, 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 ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other_____	☐ May be posted in office ☐ May be posted on website ☐ 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.

_____Date _____

Patient/Guardian