Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth: _____

Lowry Dentistry is authorized to release personal health information about the above named patient in the following manner and/or to selected persons.

CHECK EACH APPROVED TO RECEIVE INFORMATION

☐ **Other person(s)**

Name: _____ Name: _____

Relation to patient: _____ Relation to patient: _____

Phone number: _____ Phone number: _____

Email: _____ Email: _____

☐ **Phone call**
☐ **Text**

☐ **Email**

☐ **For text and/or email communication** I understand that if the information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.

☐ **Financial information**
☐ **Dental/medical health information**

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- 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)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)