**Authorization for Release of Information – Compound Release**

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| Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My **Protected Health Information** includes but is not limited to:   1. Information I have completed on any document for the clinic 2. Treatment Summary and Consents 3. Appointment Information including broken appointments and patient status 4. Financial Information including insurance coverage, account balance, and financial status   **The Wilkes Public Health Dental Clinic is authorized to release protected health information about the above named patient in the following manner and /or to the following authorized individuals.**  ⃝ Voice Mail ⃝ Results of lab test/x-rays  ⃝ Financial  ⃝ \*Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Appointment Reminders  ⃝ Medical  ⃝ \*Text number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Breach Notification  \*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 email and/or text communication as selected.    Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Photos and Media**  Photos of the above named patient whether received by the patient or legal guardian, taken by Wilkes Public Health Dental Clinic staff, or by the local newspaper may be:  ⃝ Posted in the office of the Wilkes Public Health Dental Clinic  ⃝ Posted on the website of the Wilkes Public Health Dental Clinic  ⃝ Posted in the local newspaper |

**Patient Rights:**

* I have the right to revoke/cancel this authorization at any time.
* I may inspect or ask for a copy the protected health information to be disclosed as described in this document.
* Cancelling authorization 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 re-disclosure 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 assume the responsibility for all communication directly with this office including confirming appointments, etc.

This authorization will remain in effect until revoked by the patient.

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

Signature of Patient or Legal Guardian

(HIPAA-Compound Release 4-16)