

# Norwood Dental Care

## Authorization for Release of Information – Compound Release

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

Norwood Dental Care 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.
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<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Appointment Reminders
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<input type="checkbox"/> Other person (s) (provide name and phone number)(i.e. Spouse, Parent, Grandparent, Stepparent, Friend etc) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Financial <input type="checkbox"/> Treatment
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<input type="checkbox"/> Email communication-Provide email address* _____ *	<input type="checkbox"/> Financial <input type="checkbox"/> Treatment <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
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<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
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\*For text communication to occur, accept the disclosure below:

For **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 text communication as selected.

### 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 \_\_\_\_\_

Signature of Patient or Personal Representative

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

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