Authorization to Release Health Information – Compound Release

Name of Patient: _____ Date of Birth:_____

_____ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

<table>
<tr><th>CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.</th><th colspan="2">CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.</th></tr>
<tr><td>☐ Voice Mail</td><td colspan="2">☐ Results of lab tests/x-rays
☐ Other:</td></tr>
<tr><td>☐ Other(s): (provide name and phone number)
_____
_____</td><td>☐ Financial</td><td>☐ Medical</td></tr>
<tr><td>☐ Email communication-Provide email address*
_____
*For email communication to occur, please accept the disclosure below.</td><td>☐ Financial
☐ Medical</td><td>☐ Appointment reminders
☐ Breach notification</td></tr>
<tr><td>☐ Text communication – Provide number *
_____
*For text communication to occur, accept the disclosure below.</td><td colspan="2">☐ Appointment reminder
☐ Other: _____</td></tr>
<tr><td colspan="3">☐ * 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.</td></tr>
<tr><td>☐ Photo of patient received by patient or legal guardian
☐ Photo taken by staff (Example: pre/post procedure)
☐ Other: _____</td><td colspan="2">☐ May be posted at the office
☐ May be posted on website
☐ Other:_____</td></tr>
</table>

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)