DENTISTRY
OF THE PINES
Advanced Dentistry with Southern Hospitality

Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth _____________

Dentistry of The Pines is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Way to Receive Information. Check each way you approve to receive information.	**Description of information to be released.** Check each item to be given on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* __________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ 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	☐ May be posted in office
☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website or Facebook page
☐ Other	☐ 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.

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Signature of Patient or Personal Representative ***Date***

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