

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____	
_____ 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.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays
	<input type="checkbox"/> Other _____
Relationship to patient, First , Last name and Date of Birth	
<input type="checkbox"/> DENTIST: List Doctor's/Pratice Name, Address & Phone number:	
<input type="checkbox"/> Email communication-Provide email address* _____	<input type="checkbox"/> Financial
	<input type="checkbox"/> Medical
	<input type="checkbox"/> Appointment reminders
	<input type="checkbox"/> Breach notification
*For email communication to occur, please accept the disclosure below:	
<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder
	<input type="checkbox"/> Other: _____
*For text communication to occur, accept the disclosure below:	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian	<input type="checkbox"/> May be posted in office
<input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) DR JANA TUMPKIN MCQUEEN	<input type="checkbox"/> May be posted on website
<input checked="" type="checkbox"/> Other MICHIGAN ORTHODONTIC SPECIALISTS: SOUTHFIELD, DEARBORN & CLINTON TOWNSHIP, MI.	<input type="checkbox"/> Other _____
Patient Rights:	
<ul style="list-style-type: none"> • 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)
