FOX DENTAL ASSOCIATES

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Authorization for Record Release of Information – Compound Release

Name of Patient _____ Date of Birth_____

Fox Dental Associates 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 a person/ entity 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, 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:
We work with a third party for email and text communications, which uses encryption. ○ 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 communication.	
○ Photo of patient received by patient or legal guardian ○ Photo taken by office staff (Example: pre/post procedure) ○ Other	○ May be posted in office ○ May be posted on website ○ 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 in this document.**
- **Revocation is not effective in the cases where the information has already been disclosed but will be effective going forward.**
- **Information used or disclosed because 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.

Signature of Patient or Personal Representative:_____

Date:_____

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