Authorization for Release of Information – Compound Release

Name of Patient ________________________________ ***Date of Birth*** ____________________

LAURA L. WELLENER, D.D.S., P.A. is authorized to release protected health information about the above named patient in the following manner and to the following 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.
☐ Self ________________________	☐ Medical / Dental
☐ Other person(s) ________________________	☐ Financial
________________________	☐ Appointment Reminders
________________________	☐ Results of x-rays / lab tests
________________________	☐ Breach Notification
	☐ Other: ________________________
☐ **Voicemail / Voice Message** ○ Phone Number: ________________________	
☐ **Text Message Communication** ○ Phone Number: ________________________	
☐ **E-mail Communication** ○ E-mail Address: ________________________	***For e-mail or text message communication to occur, please accept the disclosure below:**
☐ For **e-mail and/or text message 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
	☐ 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)