

# Asheville Family Dentistry

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## Authorization for Release of Information – Compound Release

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Asheville Family Dentistry is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Please check below how we may contact you & what information may be left/discussed.

Check all that apply.

Voice Mail

Text Messaging

Treatment Information

Appointment reminders

Spouse (provide name and phone number)

Financial

Dental

Parent/Child/Other (provide name and phone number)

Financial

Dental

Email communication-Provide email address\*

\_\_\_\_\_

Financial

Treatment Information

Appointment reminders

Breach notification

\*In order for email communication to occur, please accept the disclosure below:

For **email 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 move forward to allow email communications to occur.

### 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.

The information is released at the patient's request and 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)