Holloway Family Dentistry
Authorization for Release of Information - Compound Release

Name of Patient _____ Date of Birth _____

Holloway Family Dentistry 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.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other _____
☐ Other person (x) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication - Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Appointment Reminder ☐ Medical ☐ 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 send in an encrypted manner there is a risk if could be accessed inappropriately. I still elect to receive email and/or text consultation as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by 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 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.

_____ _____

Signature of Patient or Personal Representative Date

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

Revised Oct 2014