

Name: _____

DOB: _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____ SENSENBRENNER PRIMARY CARE is authorized to release protected health information about the above named patient in the following manner and/or to the selected person(s).

Check each person/entity approved to receive information.	Check type of information 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 _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address ¹ _____ ¹ For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number ¹ _____ ¹ For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
¹ 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"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____
Patient Rights: <ul style="list-style-type: none"> I have the right to revoke this authorization at any time by contacting our office. 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 may 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)