Compound Authorization for Release of Information

This authorization form permits: **KEOWEE FAMILY DENTISTRY**

15680 Wells Hwy, Seneca, SC 29678

to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ **Birth Date** _____

Address _____

City/State/ Zip _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voice mail Home #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voice mail Business # _____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voice mail Cell phone #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Spouse (Provide name) _____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____ _____
Parent (Provide name) _____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient or_____.

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

Written authorization signed by the patient/guardian to include date of birth of said patient(s).

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____Date _____

Signature of Patient/Guardian or Personal Representative (as defined by HIPAA)

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

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Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient