Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Warren & Miller Dentistry is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to receive Information Check below, each person/entity that you approve to receive the information on it's right	**Description of Information to be released** Check below, information that can be given to the person/entity on it's left
❑ Voice Mail ❑ Text ❑ Email	❑ Results of lab tests/x-rays ❑ Appointment information
❑ Employer ❑ School	❑ Appointment absentee information
❑ Spouse ❑ Parent/Guardian (provide name) _____	❑ Family billing information ❑ Financial ❑ Medical
❑ Dental offices ❑ Medical offices	❑ Patient chart/x-rays (upon your request) ❑ Patient chart/x-rays (upon their request)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document, by sending a written notification to **Warren & Miller Dentistry** . I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

_____ Date _____

(Signature of Patient or Guardian)