WAFELBAKKER ANDERSON
ORTHODONTICS

Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth _____

_____ is authorized to release protected health information about the above-mentioned patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	**Check type of information that can be given to person/entity on the left column in the same section.**
☐ Voice Mail	☐ Results of lab test/x-rays ☐ Other: _____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication – Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text Communication – Provide number* _____ *For text communication to occur, please accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ 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.	
☐ 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 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 maybe 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.

_____ Date _____

Signature of Patient or Personal Representative

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