

Authorization for Release of Information

Name of Patient _____ Date of Birth _____	
HAMILTON & HERRING ORTHODONTICS 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.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Treatment related information
<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* _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
*For email communication to occur, please accept the disclosure below:	
<input type="checkbox"/> Text communication – Provide number * _____	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
*For text communication to occur, accept the disclosure below:	
<input type="checkbox"/> 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"/> May be posted in office
<input type="checkbox"/> Photo taken by staff (Example: pre/post procedure)	<input type="checkbox"/> May be posted on website

<p>Patient Rights:</p> <ul style="list-style-type: none"> • 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. _____ Date _____

 Signature of Patient or Personal Representative

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