# Authorization for Release of Information – Compound Release

Name of Patient_____Date of Birth _____

**New Bern Family Dentistry** is authorized to release protected health information about the above-named patient in the following manner.

| **Ways you prefer we contact you:** | **Description of information we may release:** |
|---|---|
| ☐ Voice Mail<br>☐ Email: _____<br>☐ Text: _____<br>**Please Note:**<br>For email and text communication: The information may not be encrypted and there is a risk it could be accessed inappropriately. | ☐ Appointment reminders<br>☐ Financial<br>☐ Medical<br>☐ Results of lad tests/x-rays<br>☐ Breach Notification<br>☐ Other: _____ |

**Please list anyone allowed to have access to your *protected health information*, such as a family member, spouse, partner, etc. For minors, please list parents/guardians here also:**

## Photo Consent:

☐ Photo taken by staff may be posted on website or in office. (example: photo for chart, pre/post procedure, etc.)

☐ Photo of patient received by patient or legal guardian may be posted on website or in office.

☐ Photo/X-ray taken by staff can be emailed to referred doctor/specialist.

**Patient Rights:**

* I have the right to revoke this authorization at any time by contacting the 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 have the right to refuse to sign this authorization and that my treatment will not be affected by my refusal.

**This authorization will remain in effect until revoked by the patient.**

_____ _____

Signature of Patient, Guardian or Personal Representative Date

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have been given the opportunity to review **OR** receive a copy of the *Notice of Privacy Practices for New Bern Family Dentistry.*

_____ _____

**Signature of Patient, Guardian or Personal Representative** **Date**

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