Authorization for Release of Information – Compound Release

NameofPatient_____Date ofBirth_____

DAVIS ORAL SURGERY is authorized to release protected health informationaboutthe above-named patient in the following manner and/or to selectedpersons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of labtests/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 ☐ Breachnotification
☐ Text communication – Provide number * _____ *For text communication to occur, 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 legalguardian	☐ May be posted inoffice