## **Authorization for Release of Information – Compound Release**

Andy Hollifield, DMD, PA is authorized to release PHI about the above named 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 IN THE SAME SECTION.  Appointment Reminders  Appointment Reminders  Appointment Reminders  Financial  Treatment  Appointment reminders  Financial  Treatment  Appointment reminders  Breach notification  Text communication - Provide number *  For text communication to occur, accept the disclosure below:  For email and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still efect to receive email and/or text communication as selected.  Patient's Rights:  I have the right to revoke this authorization at any time by contacting this office  I have the right to revoke this authorization and that information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still efect to receive email and/or text communication as selected.  Patient's Rights:  I have the right to revoke this authorization and any time by contacting this office  I have inspect or copy the protected beath information to be disclosed as described in this document.  I have the right to revoke this authorization and that my treatment will not be conditioned on signing.  This authorization will remain in effect until revoked by the patient.  Signature of Patient or Personal Representative's Authority (attach necessary documentation).	Name of Patient:	Date of Birth:	
CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.  CHECK EVALOPERSON/ENTITY ON THE LEFT IN THE SAME SECTION.  Appointment Reminders  Appointment Reminders  Financial  Treatment  Financial  Treatment  Appointment reminders  Financial  Treatment  Appointment reminders  Breach notification  Text communication - Provide number *  For text communication to occur, accept the disclosure below:  For email and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.  Patient's Rights:  I have the right to revoke this authorization at any time by contacting this office.  I 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.  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 unthorization and that my treatment will not be conditioned on signing.  This authorization will remain in effect until revoked by the patient.  Signature of Patient or Personal Representative:  Date:			
RECEIVE INFORMATION.  BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.  Appointment Reminders  Other person (s) (provide name and phone number)( Example: Spouse, Parent, Grandparent, Stepparent, Relative etc)  Email communication-Provide email address*  Email communication-Provide email address*  Financial Treatment  Appointment reminders Breach notification  Text communication - Provide number * For text communication to occur, accept the disclosure below:  Total and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.  Patient's Rights:  I have the right to revoke this authorization at any time by contacting this office. I may inspect or copy the protected health information to be disclosed as described in this document. I may inspect or copy the protected health information to be disclosed as described in this document. I may inspect or receive in case where the information has already been disclosed but will be effective going forward. Recative of Patient or Personal Representative:  Date:  Date:  Date:	and/or to selected persons.		
□ Other person (s) (provide name and phone number) ( Example: Spouse, Parent, Grandparent, Stepparent, Relative etc)  □ Email communication-Provide email address* □ Financial □ Treatment □ Appointment reminders □ Provide number * □ Appointment reminders □ Provide number * □ Other: □ For email and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.  Patient's Rights: □ I have the right to revoke this authorization at any time by contacting this 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 conditioned on signing.  This authorization will remain in effect until revoked by the patient.  Signature of Patient or Personal Representative:		BE GIVEN TO PERSON/ENTITY ON THE	
Example: Spouse, Parent, Grandparent, Stepparent, Relative etc)    Treatment	□ Voice Mail	□ Appointment Reminders	
Email communication-Provide email address*	Example: Spouse, Parent, Grandparent, Stepparent,		
Treatment   Appointment reminders   Breach notification     Text communication – Provide number *   Appointment reminder   Other:     For text communication to occur, accept the disclosure   Other:     For email and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.    Patient's Rights:     I have the right to revoke this authorization at any time by contacting this 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 conditioned on signing.     This authorization will remain in effect until revoked by the patient.     Signature of Patient or Personal Representative:   Date:			
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V2020.1

□ Revoked l	by patient or personal representative on _	epresentative on .	
	-	DATE	
How revoked:	□ orally (in person or via phone)	□ in writing (place copy	in patient's file)

## Andy Hollifield, DMD, PA

Acknowledgement of Receipt Of Notice of Privacy Practices		
Patient Name & Address:		
have received a copy of the Notice of Privacy Practices for the above named practice.		
Signature	Date	
	For Office Use Only	
We were unable to obtain a written acknow	wledgement of receipt of the Notice of Privacy Practices	
because:		
☐ An emergency existed & a sign	nature was not possible at the time.	
☐ The individual refused to sign.		
□ A copy was mailed with a requ	nest for a signature by return mail.	
<ul> <li>Unable to communicate with the</li> </ul>	he patient for the following reason:	
Other:		
Prepared By		
G:		
Date		