# Authorization for Release of Information – Compound Release

Name of Patient: _____ Date of Birth: _____

**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. |
|---|---|
| ☐ Voice Mail | ☐ Appointment Reminders |
| ☐ Other person (s) (provide name and phone number)( Example: Spouse, Parent, Grandparent, Stepparent, Relative etc)<br>☐ _____<br>☐ _____ | ☐ Financial<br>☐ Treatment |
| ☐ Email communication-Provide email address*<br>_____ | ☐ Financial<br>☐ Treatment<br>☐ Appointment reminders<br>☐ Breach notification |
| ☐ Text communication – Provide number *<br>_____<br>*For text communication to occur, accept the disclosure below: | ☐ Appointment reminder<br>☐ Other:<br>_____ |
| ☐ 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: _____

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

□ Revoked by patient or personal representative 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:** _____

_____

_____

I 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 acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____