

OYSTER POINT FAMILY PRACTICE

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

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_____ 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.

Voice Mail

Results of lab tests/x-rays

Other _____

Other person (s) (provide name and phone number)

Financial

Medical

Email communication-Provide email address*

Financial

Medical

Appointment reminders

Breach notification

*For email communication to occur, please accept the disclosure below:

Text communication – Provide number *

Appointment reminder

Other: _____

*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 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 legal guardian

May be posted in office

Photo taken by staff (Example: pre/post procedure)

May be posted on website

Other

Other _____

Patient Rights:

- 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) _____