Authorization for Release of Information – Compound Release

Name of Patient________________________________ Date of Birth ____________________

CARLYLE DENTAL is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	**Information that can be given to person/entity on the left in the same section.**
☐ You may leave me a voicemail message at the following: Cell PH: ____________________ Home PH: ____________________	Appointments — Lab Results Billing Information — Treatment Insurance Issues — Prescriptions
☐ You may speak with or leave a voicemail with someone else: ____________________ ____________________ Name of authorized person — Phone number	Appointments — Lab Results Billing Information — Treatment Insurance Issues — Prescriptions
☐ You may **email me** at the email address below: ____________________	Appointments — Promotions Billing Information — Treatment Insurance Information — Breach Notification
☐ You may **text me** at the number below: ____________________	Appointment notifications and reminders UNCONFIRMED APPOINTMENTS MAY BE CANCELLED WITHOUT NOTICE

☐ 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.
PLEASE NOTE: Automated text message appointment reminders and emails sent by our office are encrypted and secure.

☐ I give my permission for photos of the above named patient to be shared on Carlyle Dental's website or social media.	☐ I DO NOT WANT MY PICTURES SHARED

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our 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 re-disclosure 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 person completing the form:

X____ Date____________________

If not the patient named above, what is your relationship to the patient? ____________________

Legal Representative? Type:____________________ (Attachment necessary documentation)