



AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date of Birth: _____

CASTOR FAMILY DENTISTRY is authorized to release protected health information about the above-named patient to the entities named below.

Check each person/entity approved to receive information	Check type of information that can be given to person/entity on the left of the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/ x-rays <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other person(s) (provide name & phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication – Provide email address* *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number* *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other:
<input type="checkbox"/> For email and/or text communication I understand that if notification 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.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (ex: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> 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.

Signature of Patient or Personal Representative

Date