

Inspire Dentistry of the Carolinas

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Inspire Dentistry of the Carolinas 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.
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☐ Voice Mail

☐ Appointments

☐ Other _____

☐ Other person (s) (provide name and phone number)(Example: Spouse, Parent, Stepparent, Friend, Relative etc.)

☐ Financial

☐ Treatment

☐ _____

☐ _____

☐ _____

☐ Email communication-Provide email address*

☐ Financial

☐ Treatment

☐ 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 or social media

☐ 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.

Signature of Patient or Personal Representative

Date

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

Revised Oct 2014