Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Massari-Wilson Family Dentistry is authorized to release protected health information about the above-named patient in the following manner and to the identified individuals below.

Entity to Receive Information. Check each ☐ 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/exam findings ☐ Post-op calls ☐ Responses to dental questions/messages ☐ Appointment reminders/changes ☐ Other_____
☐ Following Individuals** (provide name and phone number): _____ _____ _____ **Spouse, child, sibling, nanny, grandparents, etc.	☐ Financial ☐ Dental/Medical ☐ Appointment reminders/changes ☐ Results of lab tests/x-rays/exam findings
☐ Email communication-Provide email address* _____ *Email will be sent encrypted.	☐ Financial ☐ Medical/Dental ☐ Appointment reminders ☐ Breach notification ☐ Post-op calls, responses to dental/medical questions/messages
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Post-op calls, responses to dental/medical questions/messages ☐ Financial ☐ Medical/Dental
☐ *DISCLOSURE: For **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 text communication as selected.	
☐ Photo of patient received by patient or legal guardian. ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office. ☐ May be posted on website. ☐ Other_____
☐ US Mail	☐ Appointment reminders (post-cards)

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 because 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)**

Revised Oct 2014