Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Chart #_____

Hamilton & Whitecotton Orthodontics is authorized to release protected health information about the above named patient in the following manner and to these identified persons.

Entity to Receive Information. List 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.
Name:_____ **Relation:**_____	☐ Financial ☐ Medical
Name:_____ **Relation:**_____	☐ Financial ☐ Medical
Name:_____ **Relation:**_____	☐ Financial ☐ Medical

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 Responsible Party/Representative

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

_____

(Relationship to PATIENT)

HAMILTON & WHITECOTTON

ORTHODONTICS

Revised Oct 2014