TRUECARE DENTISTRY
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Authorization for Release of Information - Compound Release

Name of Patient:	**Date of Birth:**

Family & Cosmetic Dentistry is authorized to release protected health information about the above named patient in the following manner:

Entity to Receive Information
- ❑ Voice Mail
- ❑ Spouse
- ❑ Parent
- ❑ Email

Spouse Name:

Share with Spouse:
- ❑ Financial Information
- ❑ Medical Information

Parent Name:

Share with Parent:
- ❑ Financial Information
- ❑ Medical Information

Email (Your email address):

Email:
- ❑ Financial Information
- ❑ Medical Information
- ❑ Breach Notification

In order for email communications to occur, please accept the disclosure below:

For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communications:
- ❑ Yes

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.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Date:

Signature of Patient or Personal Representative:

Description of Personal Representative's Authority (provide office with necessary documentation):