Locust Family Dentistry
Authorization for Release of Information – Friends & Family

Patient Name and Address:_____

Entity to Receive Information:
( ) Spouse (provide name and phone number) ( ) Parent (provide name and phone number)

_____ _____

( ) Other (provide name and phone number)

_____

( ) Email Communication (provide email address)*

_____

( ) Would you like to receive appointment reminders via text messages? YES or NO

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

( ) For email 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 move forward to allow email communication to occur.

Description of information to be released. Check each that can be given to person/entity in this section:

( ) Family Billing / Financial Information
( ) Voice Mail / Appointment Reminders
( ) Dental Treatment Plans / X-Rays
( ) Breach Notification

Patients Rights:

- I understand that 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 re-disclosure 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.

_____

Signature of Patient or Personal Representative: Date:
Description of Personal Representative's Authority (attach necessary documentation)