Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Boone Endodontics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

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.
☐ Voice Mail ☐ Email (Please supply email address below) _____	☐ Results of lab test/x-rays ☐ Other _____
☐ Spouse (please provide name & phone below) _____ _____	☐ Financial ☐ Medical as follows:_____ _____
☐ Parent (please provide name & phone below) _____ _____	☐ Financial ☐ Medical as follows:_____ _____
☐ Other (please provide name & phone below) _____ _____	☐ Financial ☐ Medical as follows:_____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used to disclose 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked by the patient.**

_____ Date _____

Signature of patient or Personal Representative

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

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