

## Authorization for Release of Information – Compound Release

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Drs. Fussell, Humphreys & Harrell, PA is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

| Please list a person that we can release your information to about YOU.  | Check type of information that can be given to person on the left in the same section.   |
|--|--|
| Name _____<br>Relationship to patient _____<br>Phone number _____  | <input type="checkbox"/> Financial<br><input type="checkbox"/> Dental  |
| Emergency contact information, if same as above<br>circle Yes or No<br><br>If other: Name _____<br>Phone number _____  |  |
| Please check how we may contact you.   | Check type of information.   |
| <input type="checkbox"/> Email communication<br><input type="checkbox"/> Text communication<br><input type="checkbox"/> Voicemail communication/Landline   | <input type="checkbox"/> Financial<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Appointment reminders<br><input type="checkbox"/> Breach notification<br><input type="checkbox"/> All of the above |
| <input type="checkbox"/> For email and/or 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 email and/or text communication as selected. |  |

**Patient Rights:**

- I have the right to revoke this authorization at any time by contacting our office.
- 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 Personal Representative

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

Revised Feb 2019