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_____ Relationship to patient_____ Phone number_____	☐ Financial ☐ Dental
Emergency contact information, if same as above circle Yes or No If other: Name _____ Phone number_____ _____ _____	
Please check how we may contact you.	**Check type of information.**
☐ Email communication ☐ Text communication ☐ Voicemail communication/Landline	☐ Financial ☐ Dental ☐ Appointment reminders ☐ Breach notification ☐ All of the above
☐ 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