



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
COMPOUND RELEASE**

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

I wish to be contacted in the following manner (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Home Telephone No.: _____ | <input type="checkbox"/> Written communication |
| <input type="checkbox"/> Leave message with detailed information | <input type="checkbox"/> Mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Mail to my work/office address |
| <input type="checkbox"/> Work Telephone No.: _____ | <input type="checkbox"/> Fax to this number: _____ |
| <input type="checkbox"/> Leave message with detailed information | <input type="checkbox"/> Emailed* to: _____ |
| <input type="checkbox"/> Leave message with call-back number only | *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 receive email communication as selected. |
| <input type="checkbox"/> Cellphone No.: _____ | |
| <input type="checkbox"/> Leave message with detailed information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Leave message with call-back number only | _____ |

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.

- | | |
|---|---|
| <input type="checkbox"/> Other person (s) (provide name and phone number) | <input type="checkbox"/> Financial |
| | <input type="checkbox"/> Entire Record |
| | <input type="checkbox"/> Psychotherapy Notes |
| | <input type="checkbox"/> Office Visit Notes |
| | <input type="checkbox"/> Diagnostic Studies |
| | <input type="checkbox"/> Specific Conditions (describe) |

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

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 July 2017