Authorization for Release of Information

Patient Name: _____

DOB: _____

I authorize Walsh Dental Group to release protected health information to the entities named below for the purpose of informing the patient of information and/or any necessary instructions for the patient.

Please indicate the type of communication you are authorizing by marking "yes" or "no" below

Voice Mail (list phone number _____)
- Financial Information……..YES NO
- Dental/treatment plan/procedure information……..YES NO

Email (list address _____)
- Financial information……..YES NO
- Dental/treatment plan/procedure information……YES NO

Parent (for patients 18+)
- List parent's name(s) _____
- Financial information……YES NO
- Dental/treatment plan/procedure information……YES NO

Family members

Please list all individuals you are comfortable with receiving information regarding your treatment. This can be a spouse, sibling, extended family member, etc.

_____

_____

_____

_____

- Financial information……YES NO
- Dental/treatment plan/procedure information……YES NO

Text Message for Appointment Verification……YES NO

Please initial this statement: I understand that text communication is not sent in an encrypted manner and as such, there is a risk that the information contained in the text message may be accessed inappropriately. I acknowledge this and still elect to receive text communication.

_____(patient initials)

PATIENT RIGHTS AND 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 the revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to 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.

_____ _____

Signature of Patient/Guardian Date