Authorization for Release of Information

Patient Name: _________________________ Date of Birth: __________________________

I, _______________________________, authorize ***LandMark Dentistry*** to release protected health information to entities named below for the purpose of informing the patient of information and/or any necessary instructions for the patient.

Voice Mail:
Yes: ___ No: ___
Phone number(s): ____
I authorize LandMark Dentistry to leave information on my voice mail regarding:
Financial Information: ___
Dental/treatment plan/procedure Information: ___

Email:
Yes: ___ No: ___
Email Address: ____
I authorize LandMark Dentistry to communicate through my email regarding:
Financial Information: ___
Dental/treatment plan/procedure Information: ___

Text Message for appointment verification:
**For text communication, I understand that if text is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive text communication. (please initial this statement) ___
Yes: ___ No: ___
Mobile phone number: ____________________________

Spouse:
Yes: ___ No: ___
Name and Phone number(s): ____
I authorize LandMark Dentistry to leave information with my spouse regarding:
Financial Information: ___
Dental/treatment plan/procedure Information: ___

Parent (for patients 18+):
Yes: ___ No: ___
Name(s) and Phone number(s): ____
I authorize LandMark Dentistry to leave information with my parent regarding:
Financial Information: ___
Dental/treatment plan/procedure Information: ___

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 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 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 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 or Representative Date

____

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