Connolly Orthodontics
Authorization for Release of Information – Friends & Family

Name of Patient _____ Date of Birth _____

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

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.
☐ Voice Mail	**Types of information to be left on voicemail:** Basic Appointment Reminders / Notification to contact the office
☐ Other person (s)(.i.e. Grandparent, Stepparent, Aunt, Uncle, Parent etc.). ☐ _____ ☐ _____ ☐ _____	☐ Financial ☐ Treatment – checking this option allows us to discuss treatment progress with authorized individuals when bringing minors to monthly appointments.
☐ Email communication ☐ Text communication **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.**	**Types of information to be communicated through email:** Basic Appointment Reminders / Notification to contact the office/ receipts/ requested financial information / breach notifications/ office closures **Types of information to be communicated through text:** Basic Appointment Reminders

- 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 Relation To Patient

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Revised Oct 2014