Weaver Dentistry
R. GREGORY WEAVER, DDS. | ALAN B. SYKES, DDS.

Name of Patient: _____ Date of Birth: _____

_____ is authorized to release protocol health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voicemail	☐ Results of lab tests/x-rays ☐ Other: _____
☐ Other person(s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication – Provide email address* _____ *For email communication to occur, please accept the disclosure below.	☐ Financial ☐ Appointment reminders ☐ Medical ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below.	☐ Appointment reminder ☐ Other: _____

☐ 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 cummunicaiton as selected.

Photo of patient received by patient or legal guardian	May be posted in office
Photo taken by staff	May be posted on website
Other _____	Other _____

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 because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

_____ **may release the following information:**
(Name of Entity)

- ☐ Entire Record
- ☐ Marketing*
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released
- ☐ Diagnostic studies (list):
- ☐ Other as listed

*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

- ☐ **Send the information electronically, Email address: _____**
- ☐ 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 move forward to allow email communication to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

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 because of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Patient Representative **Date**

*Description of Personal Representative's Authority (attach necessary documentation)