Authorization for Release of Information – Compound Release

Shenandoah Oral and Facial Surgery, PLC is authorized to release protected health information about the patient listed below in the following manner and to identify persons.

*****If someone calls who is **NOT** listed, we **CANNOT** and **WILL NOT** release any information to them about the patient or their account with our office. *****

Patient Name : _____ D.O.B. : _____ Chart #: _____

Where can we leave a message (check all that apply) :	**What information may we leave :**
○ Home _____	○ Appointment reminders
○ Cell _____	○ Results of lab tests/x-rays
	○ Other_____

Person(s) to Receive Information : Check each person(s) that you approve to receive information.	**Description of information to be released :** Check each that can be given to person(s) on the left in the same section.
Name of Person(s)	
○ _____	○ Financial
○ _____	○ Medical
○ _____	○ Appointment reminders

Release of information for insurance purposes (in order to process insurance claims) :

- ○ Photo ID of patient or legal guardian
- ○ Photo taken by staff (Ex: pre/post procedure)
- ○ Copies of insurance cards

Patient Rights:

I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
I may inspect or copy the protected health information to be disclosed as described in this document.
Information used or disclosed as a result of this authorization may be subject to re-disclosure 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.

_____ _____

Signature of Patient or Personal Representative Date

_____

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

For Office Use Only:

Signature of Practice Representative: **_____**