



Authorization for Release of Information – Compound Release

Patient Name:	
Patient Date of Birth:	
Garrisonville Dental is authorized to release protected health information as described below for the identified patient.	
Entity to Receive Information. Check each person or class of persons 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.
<input type="checkbox"/> Voice Messages on _____ number.	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Other
<input type="checkbox"/> Spouse or Significant Other: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
<input type="checkbox"/> Other Person: _____	<input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Lab Results <input type="checkbox"/> Treatment Notes and Record <input type="checkbox"/> Discuss Treatment
This authorization will remain in effect until I revoke it in writing, or on the date listed below: _____ Date _____	
Signature of Patient or Personal Representative	
Description of Personal Representative's Authority (attach necessary documentation) :	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian	
Date this Authorization Expires: _____	