MARK R. BAGBY, DDS

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Authorization for Release of Private Health Information—Compound Release

Name of Patient: ____________________________ **Date of Birth:** _______________

Preferred Contact Phone #: ____

May we leave a voice mail for you that includes sensitive information? ☐ **YES** ☐ **NO**

Mark Bagby, DDS is authorized to release protected health information about the above named patient in the following manner and to identified persons.

May we discuss your information with others such as a Spouse or Parent? ☐ **YES** ☐ **NO**

(If yes, please provide name, relationship to patient, and phone number below and select applicable box(es) to the right.)

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER		
			☐ Financial	☐ Medical
			☐ Financial	☐ Medical
			☐ Financial	☐ Medical

May we send you information via text message?* ☐ **YES** ☐ **NO**

When I mark YES, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, and I still elect to receive text communications.

(If yes, please select applicable box(es) below.)

☐ **Appointment Reminder** ☐ **Other:** _____________________________________

May we send you information via email?* ☐ **YES** ☐ **NO**

When I mark YES, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately, and I still elect to receive email communications. (Select applicable box(es) below.)

____
Email Address

☐ **Financial** ☐ **Medical**
☐ **Appointment Reminder** ☐ **Breach Notification**

☐ **May we use photos received by you?** ***(If yes, how may we use them? Select applicable box(es) to the right.)*** ☐ **Post in Office** ☐ **Post on Website** ☐ **Other:** ____

☐ **With prior verbal notification, may we take photos of you?** ***Example: Pre/Post Procedure (If yes, how may we use them? Select applicable box(es) to the right.)*** ☐ **Post in Office** ☐ **Post on Website** ☐ **Other:** ____

Patient Rights:

- 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 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 in writing.

____ Date: __________________________
Signature of Patient or Personal Representative

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

9/21/15