



APPLE VALLEY

DENTAL GROUP

Authorization for Release of Information – Compound Release

Patient Name:	
Patient Date of Birth:	
Apple Valley Dental Group is authorized to release protected health information as described below for the identified patient.	
Entity to Receive Information.	Description of information to be released.
Check each person or class of persons that you approve to receive information.	Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Messages on _____ number.	<input checked="" 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
Patient Rights:	
<ol style="list-style-type: none"> 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 I revoke it in writing, or on the date listed below:	
Signature of Patient or Personal Representative _____	Date: _____
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: _____	