



### Compound Authorization Form

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

The purpose of this authorization is to inform the patient or others with pertinent patient information. The patient has requested that Carolina Family Dentistry is to release the following information about the above named patient to the entities named below:

\_\_\_ Voice Mail and/or Answering Machine phone number \_\_\_\_\_  
\_\_\_ Appointments \_\_\_ Instructions (Pre/Post Procedure/Operation)  
\_\_\_ Financial \_\_\_ Lab/test results \_\_\_ Medical \_\_\_\_\_

\_\_\_ Email email address \_\_\_\_\_  
\_\_\_ Appointments \_\_\_ Instructions (Pre/Post Procedure/Operation)  
\_\_\_ Financial \_\_\_ Lab/test results \_\_\_ Breach information details  
\_\_\_ Medical \_\_\_\_\_

\_\_\_ Text message phone number \_\_\_\_\_  
\_\_\_ Appointments \_\_\_ Instructions (Pre/Post Procedure/Operation)  
\_\_\_ Financial \_\_\_ Lab/test results \_\_\_ Medical \_\_\_\_\_

\_\_\_ Spouse Name \_\_\_\_\_  
\_\_\_ Appointments \_\_\_ Instructions (Pre/Post Procedure/Operation)  
\_\_\_ Financial \_\_\_ Lab/test results \_\_\_ Medical \_\_\_\_\_

\_\_\_ Other Name \_\_\_\_\_  
\_\_\_ Appointments \_\_\_ Instructions (Pre/Post Procedure/Operation)  
\_\_\_ Financial \_\_\_ Lab/test results \_\_\_ Medical \_\_\_\_\_

#### Right of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to \_\_\_\_\_. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as 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 understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

\_\_\_\_\_  
Signature of Patient or Legal Representative Date \_\_\_\_\_

\_\_\_\_\_  
Description of Legal Representative Authority (provide supporting documentation)