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 Karen Torres DDS PA 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)

____ Lab/test results ____ NPP ____ Breach information details

____ Financial ____ 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 Karen Torres DDS PA at 100 Parkway Office Ct, Suite 206, Cary NC 27518. 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.

_____ Date_____

Signature of Patient or Legal Representative

_____

Description of Legal Representative Authority (provide supporting documentation)