# Dr. Robert L. Schmidt, DMD PLLC

Authorization for Release of Information - Compound Release

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Name of Patient______________________________________Date of Birth________________

**Robert L. Schmidt, DMD PLLC** is authorized to release protected health information about above named patient in the following manner and/or to selected persons.

| Check each person/entity approved to receive information. Check the type of information that can be given to person/entity on the left in the same section. | |
|---|---|
| □ Voice Mail | □ Results of lab tests/x-rays<br>□ Other________________ |
| □ Other persons(provide name and phone number) | □ Financial<br>□ Medical |
| □ Email communication Provide email address below<br>__________________________________________<br>For email communication to occur please accept the disclosure below. | □ Financial<br>□ Medical<br>□ Appointment reminders<br>□ Breach notification |
| □ Text communication<br>Number__________________________<br>For text communication to occur please accept disclosure below. | □ Appointment reminder<br>□ Other_________________ |
| □ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. | |
| □ Photo Release<br>Photo taken by staff may be posted in office or on website. | |

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 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 revoked by the patient.

______________________________________________________ Date ___________________
Signature of Patient or Personal Representative.