Family Medicine of SayeBrook

Patient Name: _____

Account #: _____

Date of Birth: _____

Compound Authorization for Release of Information

Family Medicine of SayeBrook, LLC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person authorized to receive Protected Health Information about you: Please check each person/entity that you approve to receive information.

- ☐ Spouse (provide name): _____
  Authorized to receive information regarding:
  - ☐ Financial Information
  - ☐ Medical Information
- ☐ Parent/Other (provide name or names): _____
  Authorized to receive information regarding:
  - ☐ Financial Information
  - ☐ Medical Information
- ☐ Employer and/or schools (provide name/s): _____
  Authorized to receive information regarding:
  - ☐ Appointment absentee information

I authorize Family Medicine of SayeBrook, to contact me by text message regarding appointment and prescription refill information. *I understand that SMS messages may be subject to carrier fees and are patient responsibility.*

☐ Yes ☐ No

I authorize Family Medicine of SayeBrook to access my medical and prescription history and for that information to be entered into my medical record.

☐ Yes ☐ No

I give authorization for the release of Protected Health Information by voice, text message or email.

☐ Yes ☐ No

Email address: _____

Authorized to receive information regarding:

- ☐ Extended: Test results, including but not limited to: lab, x-rays, prescription information and financial information.
- ☐ Brief: Appointment information only

Rights of the Patient

For **email and/or text communication**, I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be access inappropriately. I still elect to receive email and/or text communication as selected.

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 the document. 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 a result of the 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 Personal Representative Date

Description of Personal Representative's Authority: _____

Necessary documentation to be kept on file.