AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications with Patients and their Families, Friends, or Caregivers

This form authorizes HT Macon Sapp, D.D.S. (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and a trusted family member, friend, or caregiver. This form is optional and does not expire.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Primary Contact Number:** (___) _____
☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE	DETAILED MESSAGES PERMITTED		
☐ Primary Contact Number Above	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: (___) _____ ☐ Home ☐ Cell* ☐ Work	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None

EMAIL

☐ _____

☐ All information from this practice*

☐ Billing and appointment information only (no treatment information)

☐ Data breach notifications

* By checking this box, you confirm that you understand that email and standard SMS messaging are not confidential and are unsecure methods of communication. You also understand that sending your health information via email and standard SMS presents a risk that a third party could intercept and read your information. This practice does not recommend communicating healthcare information via email or standard SMS.

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may orally communicate to the family members, friends, or caregivers listed below. Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

Spouse/Partner: _____ (First and Last) Phone: (___) _____

Name: _____ (First and Last) Name: _____ (First and Last)

☐ This practice may **NOT** communicate with my family members, friends, or caregivers.

YOUR PHOTOS & MULTIMEDIA

☐ Photo received from you or personal representative

☐ Photo taken by staff (e.g., pre/post procedure)

☐ Other clinical images (e.g., X-ray)

☐ Other: _____

Photos/Images may be posted:

☐ In office

☐ On office's website

☐ Other: _____

ACKNOWLEDGEMENT AND SIGNATURE

- You acknowledge that information related to a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop the communications.
- An Authorization to Release Health Information or Patient Access Request must be completed for this practice to provide copies of or transmit your health information/records to anyone other than you.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative.

_____ _____

Patient/Personal Representative Signature **Date** mm/dd/yyyy

Description of Personal Representative's Authority (attach necessary documentation if not previously provided)

_____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been revoked: _____
mm/dd/yyyy

The revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy provided to patient/personal representative

Notes: _____

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