CRYSTAL COAST
ORAL & FACIAL SURGERY

Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

Crystal Coast Oral & Facial Surgery is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

May we leave a voicemail for you that includes sensitive information? ☐ YES ☐ NO
(If yes, please list the phone number where a message may be left.) (_____)-_____-_____

May we discuss your information with others such as a Spouse or Parent?
(If yes, please provide name and phone number below and select applicable box(es) to the right.)

NAME	PHONE NUMBER		
_____	_____	☐ **Financial**	☐ **Medical**
_____	_____	☐ **Financial**	☐ **Medical**
_____	_____	☐ **Financial**	☐ **Medical**

May we send you information via email?* ☐ **Financial** ☐ **Medical**
(If yes, please provide email address below and select applicable box(es) to the right.) ☐ **Breach Notification**

_____

**For email communications to occur, accept the disclosure below:*

☐ **For email 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 communication as selected.**

Patient Testimonials:

☐ May we use photos received by you? *(If yes, how may we use them? Select applicable box(es) to the right.)* ☐ **Post in Office** ☐ **Post on Website** ☐ **Other:** _____

☐ With prior verbal notification, may we take photos of you? *Example: Pre/Post Procedure (If yes, how may we use them?)* ☐ **Post in Office** ☐ **Post on Website** ☐ **Other:** _____

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 re-disclosure 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.

_____ _____

Signature of Patient or Personal Representative **Date**

***Description of Personal Representative's Authority (attach necessary documentation)**