COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient_____

Date of Birth_____

Dr. Samuel DeAngelo is authorized to release protected health information about the above names, patient or other in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
____ Voice Mail	____Results of lab tests/x-rays Other(Day & time of appt)
____Give information to employer ____Give information to school	____Appointment absentee information
____Spouse	____Family billing information ____Financial ____Medical as follows:_____
____Parent (provide name)	____Family billing information ____Financial ____Medical as follows:_____
____Other(provide name)	____Financial ____Medical as follows:_____
Support Group(provide name)	____Demographic Information

Rights 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 Dr. Samuel DeAngelo. 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 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.

Signature of Patient or Personal Representative _____Date_____