AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ______________________________, hereby voluntarily authorize the disclosure of information from my/child's health record.

Patient Name: ______________________________ Record Number: ______________

Address: ______________________________ Date of Birth: ______________

Information to Be Released: ______________________________

____

The Information Is To Be Provided To: Name of Person/Organization/Facility: ______________________________

Phone Number: ______________ Address: ______________________________

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. *Under HIPAA with a patient's written request, records must be provided within 30 days of a request.*

AUTHORIZATION TO USE AND RECEIVE EMAIL

I, ______________________________(Name of Patient/Guardian) want to communicate via e-mail with ***Windsor Smiles Orthodontics*** on matters related to my health and/or my medical treatment. I understand that any Confidential Personal Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that it is not the policy of the practice to encrypt any Confidential Personal Health Information that I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

AUTHORIZATION TO LEAVE VOICE MESSAGES

I, ______________________________ (Name of Patient/Guardian) authorize the use of voice mail messages as a way to communicate Confidential Personal Health Information. You may leave voice mail messages on the following phone lines: ***Home Phone***: ______________ ***Cell Phone:*** ______________

ACKNOWLEDGEMENT FOR NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Patient Name: ______________________________

Patient/Guardian Signature: ______________________________ Date: ______________

Witness Signature: ______________________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ Other *(Please provide specific details):* ______________________________

______________________________ ______________________________

Employee signature *Date*