KOS Endodontics
Authorization for Release of Information - Compound Release

Name of Patient _____

Date of Birth_____

KOS Endodontics is authorized to release protected health information about the above named patient in the following manner and to identify persons.

Entity to Receive Information **Information Description of Information to be released. Check each that can be given to person/entity on the left in the same section**	
Check each person/entity that you approve to receive	
○ Voice Mail ○ Email ○ Phone call	○ Appointment Reminders ○ Other
○ Other person(s) (provide name and phone number) (**Example: Spouse, Parent, Friend, Relative etc.**) ○ _____ ○ _____ ○ _____	○ Financials ○ Treatment ○ Financials ○ Treatment ○ Financials ○ Treatment
○ 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 text communication as selected	
○ _____ Email Communication- Please provide email address ○ Financials ○ Appointment reminders ○ Treatment ○ Breach notifications _____ _____	
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_____

Print Name _____

FORM Revised Oct 2014