Pinner Clinic, PA

A Rich History of Medical Tradition Since 1915

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient ____ Date of Birth:___________________

If we need to reach **you** during the day, what is the best **daytime** phone number?	Check the following information that can be provided by voice mail and/or text:
____	☐ Financial
Is this home, work or cell? _______________________	☐ Medical Information
OK to leave voice mail messages? ☐ Yes ☐ No	☐ Results of lab tests/x-rays
OK to send text messages? ☐ Yes ☐ No	☐ Appointment Information
	☐ Other: __________________________________

***Pinner Clinic, PA** is authorized to release protected health information regarding the above-named patient to the entities named below. The purpose of this form is to strictly adhere to patient instructions.*

Person/Entity to Receive Information Provide information for each person/entity that you approve to receive your information.	**Description of Information to be Released** **Check each** that can be given to the person/entity indicated on the left
Name: ____ Best Daytime Phone: ______________________________ Voice mail messages ok? ☐ Yes ☐ No	☐ Financial ☐ Medical Information ☐ Results of lab tests/x-rays ☐ Appointment information ☐ Other: __________________________________
Name: ____ Best Daytime Phone: ______________________________ Voice mail messages ok? ☐ Yes ☐ No	☐ Financial ☐ Medical Information ☐ Results of lab tests/x-rays ☐ Appointment information ☐ Other: __________________________________

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 Pinner Clinic, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective moving forward from the date listed on the form. 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.

____ ____________________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative (Attach additional information as necessary)

***This form will expire 1 year from the date listed on the form unless noted otherwise by patient. Form expiration date:** _______________________*