

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Paula I Kapec D.D.S., PLLC to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ **Main Contact Number:** (____) _____
mm/dd/yyyy

Mailing Address: _____

COMMUNICATING WITH YOU

Selecting the SMS checkbox acknowledges receipt of SMS correspondence from Paula I Kapec DDS PLLC. Message & data rates may apply. Reply STOP to opt out.

PHONE	DETAILED MESSAGES PERMITTED		
<input type="checkbox"/> Main Contact Number Above	<input type="checkbox"/> text (SMS)*	<input type="checkbox"/> voicemail/answering machine	<input type="checkbox"/> None
<input type="checkbox"/> Other: (____) _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell* <input type="checkbox"/> Work	<input type="checkbox"/> text (SMS)*	<input type="checkbox"/> voicemail/answering machine	<input type="checkbox"/> None

EMAIL*

Email Address _____

<input type="checkbox"/> All information from this practice	<input type="checkbox"/> Data breach notifications
<input type="checkbox"/> Appointment information only (request/confirm/cancel)	<input type="checkbox"/> Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

This practice may communicate to the **family members, friends, or caregivers** listed below (LIST FIRST AND LAST NAME)

Spouse/Partner: _____	Other: _____
Phone: (____) _____	Phone: (____) _____
Email:* _____	Email:* _____
	Relationship: _____

Check the box next to each type of information this practice may share.

All information Prescriptions Appointments (request/confirm/cancel) Billing/Insurance

Other: _____

Do not include:

Mental health records Communicable diseases (e.g., HIV/AIDS) Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk.
 This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

See Back →

YOUR PHOTOS & MULTIMEDIA

Photos/Images may be used/posted (select options below) **Photos/Images may NOT be used/posted**

Photo received from you or personal representative

In office

Photo taken by staff (e.g., pre/post procedure)

On office's website

Other: _____

Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

(Patient/Personal Representative Signature)

(Date)

FOR OFFICE USE & REFERENCE ONLY

This authorization has been terminated: _____

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____

Copy of original authorization provided to patient/personal representative (check if yes)

Notes:
