ELLIS K. LIST, D.D.S., P.A.
COMPREHENSIVE & ESTHETIC DENTISTRY

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# Authorization for Release of Information

**Name of Patient:**_____**Date of Birth:**_____

The office of Ellis K. List, DDS PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

**Entity to Receive Information and Description of information to be released:**

**__ Voice Mail**
- __ Lab/xray results
- __ Financials/ Insurance /Billing
- __ Appointment_____
- __ Other_____

**__ Parent/Other (name)**_____
- __ Lab/xray results
- __ Financials/ Insurance/ Billing
- __ Appointment_____

**__ Spouse (name)**_____
- __ Lab/xray results
- __ Financials/ Insurance/ Billing
- __ Appointment_____
- __ Other _____

**__Email (address)**_____
- __ Lab/xray results
- __ Financials/ Insurance/ Billing/Breach
- __ Appointment

**__Postcard (appointment date only)**

I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed improperly. I still elect to receive email communication.

## Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy, for a fee, the protected health information to be disclosed as described in this document. 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 redisclosure 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.

_____Date _____

Signature of Patient or Personal Representative (Description of Authority)
attach necessary documentation

Revised October 2013