COMPOUND RELEASE OF INFORMATION - HIPAA

Name of Patient: ______________________________________ Date Of Birth: ____ / ____ / ____

UNITY HEALTH is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

PERSON AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION ABOUT YOU:

Please check each person/entity below that you approve to receive information.

☐ Spouse (Provide Name): ____

☐ Parent (Provide Name): ____

☐ Employer (Provide Name): ____

☐ Referring Physician (Provide Name): ____

☐ Other (Provide Name): ____

I give authorization for the release of protected health information on voicemail.

☐ Yes ☐ No

I give authorization for appointment reminders via text message.

☐ Yes ☐ No

PATIENT RIGHTS:

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 writted notification to UNITY HEALTH. 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.

Signature of Authorized Person: ____________________________________ Date: ____ / ____ / ____