**Authorization- Compound Treatment & Social Media**

This authorization form permits **River Falls Pediatric Dentistry** to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Patient Name _____ Birth Date _____
Patient Name _____ Birth Date _____
Patient Name _____ Birth Date _____
Patient Name _____ Birth Date _____

| Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you. | Description of information to be given to checked Entity or Person. |
|---|---|
| Voice mail<br>#_____ | ☐ Appointment time<br>☐ Results of lab test or x-rays<br>☐ Other _____ |
| Voice mail Business<br># _____ | ☐ Appointment time<br>☐ Results of lab test or x-rays<br>☐ Other _____ |
| Unencrypted email address:<br>_____ | ☐ Appointment time<br>☐ Results of lab test or x-rays<br>☐ Other _____ |
| Text Messages<br>#_____ | ☐ Appointment time<br>☐ Other _____ |
| Any treating facility to receive PHI by unencrypted email | ☐ Unencrypted treatment information with minimal identifiers |
| Employer<br>_____<br>School<br>_____ | ☐ Appointment or absentee information<br>☐ Return to work or school information |
| Parent or Spouse & Relationship<br>Name_____<br>Relationship- _____ | ☐ Family billing information<br>☐ Financial information<br>☐ Medical information- please list<br>_____<br>_____ |
| Other (Provide name)<br>_____<br>Relationship _____ | ☐ Financial information<br>☐ Medical information- please list<br>_____<br>_____ |
| Other (Provide name)<br>_____<br>Relationship _____ | ☐ Financial information<br>☐ Medical information- please list<br>_____<br>_____ |
| General or Social Media viewing | ☐ Photos<br>☐ Other _____<br>☐ Other _____ |

**Purpose**

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

**Expiration date or event:** This authorization shall be enforce until revoked by the patient or _____

**Verification method or code:** This practice will verify the identity of any entity requesting protected health information. Verification information may include:

_____

**Rights of the Patient**

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form I understand that a revocation is not effective in cases where the information has already been used or 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.

_____Date _____
Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

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Office Use Only:

Receiving Employee_____ Date received_____

☐ Copy given to patient