PAUL H. CLONINGER, DDS, PA

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(704) 435-6916

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ___________________________ Date of Birth: ________________

Dr. Paul H. Cloninger's office is authorized to release protected health information about the above named patient to the entities' names below. The purpose is to inform the patient or others keeping with the patient's instructions.

Entity to receive information (check each entity you approve to receive your dental information)	**Information to be released (check the information you allow to be released to any selected entity of the left)**
❑ Employer ❑ School ❑ Voice Mail ❑ Spouse ______________ (name) ❑ Relative _____________ (name) ❑ Parent _______________ (name) ❑ Other _______________ (name)	❑ Results of x-rays/tests ❑ Appointment information/other ❑ Appointment absentee information ❑ Family Billing Information ❑ Financial ❑ Particular Medical/Dental Information as follows: __________________________ __________________________ __________________________

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described I this document by sending a written notification to Dr Paul H. Cloninger. 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 state law. I have received a copy of this office's Notice of Privacy Practice. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned in signing. This authorization shall be in effect until revoked by the patient.

____ ______________________

Signature of patient or personal representative Date