GRAPER COSMETIC SURGERY

Robert Graper, M.D. F.A.C.S.

Authorization for Release of Information - Compound Release

Name of Patient: _____ Date of Birth: _____

Graper Cosmetic Surgery is authorized to release protected health information about the above named patient in the following manner and to persons listed.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Email communication - Provide email address* _____ *In order for email communication to occur, please accept the disclosure below.	☐ Financial ☐ Medical ☐ Appointment Reminders ☐ Breach Notification

☐ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by patient.

_____ Date:_____

Signature of Patient or Personal Representative.*Description of Personal Representative's Authority (attach necessary documentation.)

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