Carolina Gynecology PA

Authorization for Release of Information to Family or Friends

Name of Patient: _____ DOB: _____

Carolina Gynecology PA is authorized to release protected health information about the above named patient to entities below.

Entity to receive information (*Initial each that is subject to this authorization*)

_____ Leave information voicemail/answering machine. Work ____ Home ___

_____ Give information to spouse/family/friend : _____

_____ Give Carolina Gynecology PA permission to mail results/records to my home address.

Description of information to be released

_____ Financial/billing information

_____ Test results/ x-rays/ultrasounds/labs

_____ All medical information

_____ Medical instructions (may include but not limited to prescription use & directions)

_____ Other information as described _____

Right of the patient

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to:

Carolina Gynecology PA
700 Exposition Place Suite 161
Raleigh, NC 27615

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 to disclose as a result of this information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effective until revoked by the patient or representative by signing this authorization.

_____ _____

Signature of patient or personal representative Date