Authorization for Release of Information to Family and/or Friends

Name of Patient_____ Date of Birth: _____

Entity to Receive Information:

_____ Leave information on the voice mail/answering machine _____ Mail information

Give information to the following person(s):

_____ _____

_____ _____

Description of information to be released:

_____ Financial Information _____ Results from Tests and/or x-rays _____ Billing Information

_____ Medical information as follows: _____

_____

_____ Other information as described: _____

Rights of the Patient

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 written notification to North Carolina Internal Medicine, PC. 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.

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

_____ _____

Signature of patient / Legal Guardian / Authorized person Date

_____

Description of Authorized Person (attach necessary documentation)