CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address:_____

City, State, Zip:_____ Phone:_____

_____**may release the following information on behalf of the patient:**

(Name of the entity)

☐ Entire Record ☐ Financial records ☐ Office visit notes ☐ Marketing*
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list): _____

Other (list): _____
*Financial compensation is received for this communication.

Entity or person who will receive the information:

Name:

Address:_____

City, State, Zip:_____ Phone:_____

☐ **Send the information electronically, Email address:** _____
☐ **Acknowledge for email and/or text communication** I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

This authorization shall be in effect until the information has been forwarded as requested, until the course of treatment is complete, or until revoked by the patient in writing.

Patient's Rights:
- I have the right to revoke this authorization at any time in person or in writing.
- 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 may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient in writing.

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

REVOKED

How: ☐ in person on_____. (date) If in person, signature is required.

Signature of Patient or Personal Representative:_____

☐ in writing (place copy in patient's file)

Authorization to Release Health Information – Compound Release

Name of Patient:_____Date of Birth: _____

_____is authorized to release PHI about the above named patient in the following manner and/or to selected Persons.

<table>
<tr><th>CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.</th><th colspan="2">CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.</th></tr>
<tr><td>☐ Voice Mail</td><td colspan="2">☐ Results of lab tests/x-rays
☐ Other:</td></tr>
<tr><td>☐ Other(s): (provide name and phone number)
_____
_____</td><td>☐ Financial</td><td>☐ Medical</td></tr>
<tr><td>Email communication_ Provide email address*
*For email communication to occur, please accept the disclosure below.</td><td>☐ Financial
☐ Medical</td><td>☐ Appointment reminders
☐ Breach notification</td></tr>
<tr><td>☐ Text communication – Provide number*
_____
*For text communication to occur, accept the disclosure below.</td><td colspan="2">☐ Appointment reminder
☐ Other:_____</td></tr>
<tr><td colspan="3">☐ *Acknowledge for email and/or text communication I understand that if information is not sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.</td></tr>
<tr><td>☐ Photo of patient received by patient or legal guardian
☐ Photo taken by staff (Example: pre/post procedure)
☐ Other:_____</td><td colspan="2">☐ May be posted at the office
☐ May be posted on website
☐ Other:_____</td></tr>
</table>

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
- 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.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient in writing.

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

REVOKED

How: ☐ in person on_____. (date) If in person, signature is required.

Signature of Patient or Personal Representative:_____

☐ in writing (place copy in patient's file)