Carolina Breast & Oncologic Surgery

2223 Hemby Lane
Greenville, NC 27834

Phone (252) 413-0036
Fax (252) 413-0038

AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____ **City** _____ **Zip** _____

Daytime phone number _____ **SSN (last 4 digits)** _____

Select one of the following:

___ Carolina Breast & Oncologic Surgery to provide copies to

Person/Facility:	
Address:	
City & State:	Zip:
Phone:	Fax:

___ Carolina Breast & Oncologic Surgery to obtain copies from

Person/Facility:	
Address:	
City & State:	Zip:
Phone:	Fax:

I authorize the following information to be sent to the address above (choose all that apply):

	Entire Record		Office Notes		Pathology Reports		Financial Records
	Consultations		Procedure Reports		Reports from other physicians		Other(specify)

_____ All Dates **OR** For the period from ____/____/____ to ____/____/____

Put a mark next to the purpose of the request:

	Attorney/Legal		Continued Patient Care		Insurance
	Personal Use		Social Services/Disability		Other:

Method of Delivery: (Mark one) _____Mail _____Fax _____Pick-up
Format: (Mark one) _____Paper _____Electronic _____Other

Send the information electronically. Email address: _____

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.

This authorization shall be in effect until the information has been forwarded as requested.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)