Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Carolina Breast & Oncologic Surgery is authorized to release protected health information about the above named patient in the following manner and to specific persons.

From time to time, patient's family, friends or relatives call our office asking for appointment times, medication refills, medical information regarding the patient's diagnosis, or to receive and discuss a patient's results. Without your permission, we CAN NOT talk to anyone about your treatment, other than you, our patient. If you would like our staff to be able to speak to anyone other than yourself, regarding your healthcare, please list the names of those people below:

_____ _____
_____ _____
_____ _____

****I ALSO UNDERSTAND THAT IN THE COURSE OF MY TREATMENT IT MAY BE NECESSARY FOR ME TO BE REFERRED TO ANOTHER PROVIDER AND THAT MY INFORMATION WILL BE SENT TO THE PROVIDER IN A SECURE MANNER.****

Type of Contact. *Check each contact type that you approve to receive information.*	**Description of information to be released.** *Check each type of information that may be given by this type of contact.*	
☐ Voice Mail	☐ Financial ☐ Medical	☐ Appointment reminders ☐ Results of lab tests/x-rays
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical	☐ Appointment reminders ☐ Results of lab tests/x-rays
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Financial ☐ Medical	☐ Appointment reminders ☐ Results of lab tests/x-rays
☐ For **email and/or text 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 receive email and/or text communication as selected.		

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 re-disclosure 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 will remain in effect until revoked by the patient.

_____Date _____
Signature of Patient or Personal Representative

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