HIPAA RELEASE

Patient Name_____ Date of Birth_____

Address_____City_____State_____Zip_____

Carolina Oncology Specialists, P.A. is authorized to disclose protected health information as described below.

Initial each that is subject to this authorization.

_____Leave information on my answering machine/voice mail. (if needed)

_____May call my workplace to contact me. Work # _____

_____May contact pharmacy for a prescription request. Preferred pharmacy:_____
_____Leave and/or release information to the following persons:

Name : Relation: Contact #:

_____

_____

_____

_____

Initial all releases that apply for the **above listed people** .

_____Appointment information (date, time, with whom & what for).

_____Information & results from any tests or x-rays.

_____Pick up prescriptions from office.

Initial all releases that apply for **present** and **future purposes**.

_____Information necessary to complete a prescription request.

_____Information necessary to complete forms for disability, FMLA, insurance, etc.

_____Information necessary to complete request for handicap parking tag for DMV.

_____Information necessary for dismissal from jury duty or legal proceedings.

_____Other information as described:_____

*This authorization shall be in force and effect until revoked by the patient or representative signing the authorization. The permitted use of the information is to inform the patient.

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification to Linda Travis (Practice Administrator) or Erin Baker (Privacy Officer).

I understand that a revocation is not effective in cases where 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 inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to the above named persons.

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

Signature_____ **Date**_____
(Patient or Personal Representative)

Print Name_____
(Patient or Personal Representative)

_____
***If applicable-(Description of Personal Representative's Authority-attach necessary documentation)**