Patient Name _____ ***Date of Birth*** _____

Address _____

City _____ ***State*** _____ ***Zip*** _____

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

Check each that is subject to this authorization:

- ☐ May leave information on my answering machine/voice mail.
- ☐ May call my workplace to contact me. Work #: _____
- ☐ May give verbal/electronic info for a prescription request. Preferred Pharmacy: _____
- ☐ May release information necessary to complete request forms for disability, FMLA, Insurance, etc.
- ☐ May release information necessary to complete request for handicap parking tags for DMV
- ☐ May release information necessary for dismissal from jury duty or legal proceedings.
- ☐ Other, as described_____

Enter the name, relation & phone number of each person to whom you wish to release information.
Check all boxes that apply. These persons may contact our office for information about you.

- Release test results (scans, labs, pathology, etc.)
- Allow this person to pick up prescriptions at the office
- Release information about appointments (date, time, with whom and reason)

Contact Name	***Relation***	***Phone***	Test/Scan Results	Pickup Rx	Appt Info
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending a written notification.

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 re-disclosure 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 with 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 (Patient or Representative): _____ Date_____

Print Name (Patient or Representative): _____

Description of Representative(if applicable): _____