Carolinas Fertility Institute, P.A. Authorization for Information Release – Compound Release

Name of Patient: _____ Date of Birth: _____

_____ is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
_____ Voice Mail	_____ Results of lab tests/ultrasounds _____ Other
_____ Other person (s) (provide name and phone number)	_____ Financial _____ Medical
_____ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	_____ Financial _____ Medical _____ Appointment reminders _____ Breach notification
_____ Text communication - Provide number * _____ *For text communication to occur, accept the disclosure below:	_____ Appointment reminder _____ Other:
_____ 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.	
_____ Photo of patient received by patient or legal guardian _____ Photo taken by staff (Example: pre/post procedure) _____ Other	_____ May be posted in office _____ May be posted on website _____ Other

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.

_____ _____

Signature of Patient or Personal Representative

Date

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

Revised May 2017

Carolinas Fertility Institute, P.A.

Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____Address _____

City, State, Zip _____ Phone _____

_____ **may release the following information**:
(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 as listed

Entity or person who will receive the information:

Name _____

Address _____

City, State, Zip_____Phone_____

____ Send the information via FAX to # _____ _____

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

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 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.

_____ Date _____
Signature of Patient or Personal Representative

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