Conway Physicians Group

Carolina Bays ENT

Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____Carolina Bays ENT___ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person Authorized to Receive Protected Health Information About You:
Check each person/entity that you approve to receive information.

☐ **Spouse** (provide name): _____
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

☐ **Parent** (provide name): _____
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

☐ **Employer** (provide name): _____
Authorized to receive information regarding:
- ○ Appointment absentee information

☐ **School** (provide name): _____
Authorized to receive information regarding:
- ○ Appointment absentee information

☐ **Referring Physician** (provide name): _____
Authorized to receive information regarding:
- ○ Medical Information
- ○ Appointment Information

☐ **Other** (provide name): _____
Authorized to receive information regarding:
- ○ Financial Information
- ○ Medical Information

I give authorization for the release of protected health information on voice mail.
☐ Yes ☐ No
Authorized to receive information regarding:
- ○ Results of tests that are normal (including but not limited to lab and x-rays)
- ○ Appointment Information
- ○ Prescription Refill Information
- ○ Other Information as follows:

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **_____Carolina Bays ENT_____**. I understand that a revocation is not effective in cases where the 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 refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)
_____