Compound Authorization for Release of Information

Name of Patient _____ Date of Birth _____

CAROLINA CENTER OF GYNECOLOIGIC ONCOLOGY, PA 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.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail ❑ E-Mail	❑ Medical test results ❑ Other_____
❑ Give information to employer ❑ Give information to school	❑ Appointment absentee information
❑ Spouse (provide name)_____	❑ Financial ❑ Medical as follows:_____
❑ Parent (provide name)_____ ❑ Other individuals (provide names) _____ _____	❑ Financial ❑ Medical as follows:_____
❑ Other Health Care Providers and Facilities that Participate in My Medical Care ❑ Cancer Registry ❑ Support Group _____	❑ Financial ❑ Medical as follows _____ ❑ Demographic Information

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 _____. 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)

_____