**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

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 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**:





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)

Revised May 2017