Carolina Internal Medicine Associates,P.A.
Compound Authorization for Release of Information

Name of Patient: _____ Date of Birth:_____
MR#_____
Carolina Internal Medicine Associates, P.A. is authorized to release protected medical information about the above mentioned patient to the entries 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/ Answering Machine	[ ] Results of lab and other diagnostic procedures/appointments.
[ ] Spouse/Name	[ ] Medical/Clinical [ ]Portal [ ] Financial/Billing
[ ] Other Family member/Name	[ ] Medical/Clinical [ ]Portal [ ] Financial/Billing
[ ] Parent/Name	[ ] Medical/Clinical [ ]Portal [ ] Financial/Billing
[ ] Other/Name	[ ] Medical/Clinical [ ]Portal [ ] Financial/Billing
[ ] No one other than myself	[ ] No 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 the Business Manager at Carolina Internal Medicine. I understand that a revocation is not effective in cases where information has already been released 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 state or 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/Responsible Personal (Attach Necessary Documentation)