Authorization to Release Health Information From:

Patient Information:

Name of Patient ____ Date of Birth _____________

Address____Last 4 of SS_____________

City, State, Zip _______________________________________Phone ____________________

At my request the following information may be released:

◻ Entire record
◻ Pathology ◻ Lab results
◻ Diagnostic studies

◻ Other as listed:____

<u>Please release/forward the health information to:</u>

Carolina Oncology Associates, P.A.
825 West Henderson Street
Salisbury, NC 28144-2725

FAX #: 1-855-662-2141

Phone: 704-636-5542

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 redisclosure 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.

____Date _______________________
Signature of Patient or Personal Representative

Revised August 2013

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