Authorization for Release of Information – Compound Release

Name of Patient _____ **Date of Birth** _____

Carolina Vision Associates is authorized to release protected health information about the above name patient in the following manner and to person listed.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each can be given to person/entity on the left in same section.
Voice Mail **#** _____	☐ **Pick up for glasses or contacts** **Other** _____ ☐ **Appointment Information**
Spouse or Parent (Provide name, Phone number and Relationship) **Name:** _____- _____ **#** _____	☐ **Financial** ☐ **Medical** ☐ **Pick up for glasses or contacts**
Other (Provide name, Phone number and Relationship) **Name:** _____- _____ **#** _____	☐ **Financial** ☐ **Medical** ☐ **Pick up for glasses or contacts**
Email Communication- Provide email address* _____	☐ **Financial** ☐ **Medical** ☐ **Appointment Reminders** ☐ **Breach Notification**

In order for email communication to occur, please accept the disclosure below:

☐ **For email 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 move forward to allow email communication to occur.**

Entity or Person to receive information:

School: _____

Employer:_____

☐ Return to work or school Document

General Viewing and Social Media Viewing	☐ Photos office placement Photos patient placement ☐ Contest Information ☐

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.

Verification Method and Code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:

Mothers Maiden Name: _____

Patient's Birth State: _____

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient or said expiration date.

Signature: _____ **Date**: _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation) Exp. Date: _____

Office Use Only:

Receiving Employee _____ Date Received _____

☐ Copy given to patient ☐ Patient Declined Copy