

**Authorization for Release of Information**

**Form F**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**CARY SKIN CENTER, 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.**

<p><b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.</p> <p><input type="checkbox"/> <b>No restrictions apply. Any/All information may be released to all parties named on this form.</b></p>	<p><b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.</p>
<p><input type="checkbox"/> Voice Mail</p>	<p><input type="checkbox"/> Results of pathology(s) <input type="checkbox"/> Other _____</p>
<p><input type="checkbox"/> Spouse</p>	<p><input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____</p>
<p><input type="checkbox"/> Parent (provide name) _____</p>	<p><input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____</p>
<p><input type="checkbox"/> Other (provide name) _____</p>	<p><input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____</p>

**If there is a friend or family member we can contact in the event of an emergency, please print his/her name below. This information will remain active and in your file until you request in writing that it be changed.**

Print Name	Relationship	Phone

**PATIENT INFORMATION**

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. 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 re-disclosure 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)**

\_\_\_\_\_