Central Carolina Surgery, P. A.
1002 N. Church St., Suite 302
Greensboro, NC 27401
336 387-8100
Fax 336 387-8205

Standard Authorization of Use and Disclosure of Protected Health Information

_____SS#_____Phone #_____ DOB _____
Patient Name (print)

_____ Acct # _____
Street Address (print) City Zip

Dates of_____

____Discharge Summary ____Pathology Reports ____Emergency Reports
____History & Physical ____Lab Reports
____Office Notes ____Radiology Reports
____Operative Notes ____ECG/EEG/Cardiac Cath

____ I do ____ do **NOT** authorize release of information related to AIDS or HIV Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Person/Organization to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____ ****Pt to pick up ____Mail to pt ____**
Name of person/organization

_____
Street Address City Zip

Expiration Date of Authorization/ Right to Terminate or Revoke Authorization/ Potential for Re-disclosure
I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification to the Executive committee and Administrator of Central Carolina Surgery, but that it will not affect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or organization receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized may not condition its treatment of me on whether or not I sign the authorization.

_____
Patient's Signature Date

_____
Patient's Representative Signature Relationship

Physician Signature **Date**

For office use only
____Discharge Summary ____Pathology Reports ____History & Physical ____ Lab Reports
____ Office Notes ____ Radiology Reports ____ All Records Patient Requested
____Operative Notes ____ECG/EEG/Cardiac Cath

Medical Information released by _____ on _____.
(Staff initials) (date)

smt rev 7/25/07