

Authorization for Release of Information to Family and/or Friends

Patient: _____ Date of Birth: _____

Charlotte Dermatology, PA. is authorized to release protected health information about the above-named patient to the entities named below.

Entity to Receive Information. **INITIAL EACH** that is subject to this authorization.

- Leave Information on the voicemail.
- Give information to spouse.
- Give information to the following person (s): _____

Description of information to be released

- Financial information.
- Family billing information.
- Information results from test or x-rays.
- Medical information as follows: _____
- Other information as described: _____

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 in this document by signing a written notification to Charlotte Dermatology, PA. 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 upon signing this authorization.

This Authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Representative

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