

# Carolina Elite Women's Care, PA

934 Vandora Springs Road  
Garner, NC 27529

919.977.9075 phone  
919.977.9289 fax

## HIPAA Authorization to Release Medical Information to a FAMILY MEMBER

Authorization for use or disclosure of protected health information

Complete this form if you would like to release your protected health information to a spouse, partner, parent or other person(s)/entity. This signed authorization will allow us to speak to or release your medical information to that person(s)/entity, as instructed below.

Chart#: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Patient's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Check each person(s)/entity below that you approve to receive your Medical Information, if they request.</u>	<u>Description of Information to be Released to this approved person(s)/entity.</u>
<input type="checkbox"/> Spouse/Partner  Name: _____	My <b>Spouse/Partner</b> may have the following information about my care:  <input type="checkbox"/> Complete Health Record <input type="checkbox"/> Financial/Billing Information <input type="checkbox"/> Current Pregnancy Information only <input type="checkbox"/> Other: _____
<input type="checkbox"/> Parent(s)/Guardian(s)  Name: _____  Name: _____	My <b>Parent(s)</b> may have the following information about my care:  <input type="checkbox"/> Complete Health Record <input type="checkbox"/> Financial/Billing Information <input type="checkbox"/> Current Pregnancy Information only <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other Person(s)/Entity  Name: _____  _____	The named <b>person(s)/entity</b> may have the following information about my care:  <input type="checkbox"/> Complete Health Record <input type="checkbox"/> Financial/Billing Information <input type="checkbox"/> Current Pregnancy Information only <input type="checkbox"/> Other: _____

I hereby authorize **Carolina Elite Women's Care** to release my protected health information to the approved person(s)/entity as described above. I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that the practice has already acted in reliance upon this authorization. I understand when my information is used or disclosed pursuant to this authorization, it may also be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (expires in 1 year!)

Relationship to Patient:  Self or  Parent/Guardian – Print Name: \_\_\_\_\_