901 US 70, Suite 100
Garner, North Carolina 27529
www.carolinaelitewomen.com

(phone) 919.977.7095
(fax) 919.977.9289

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:_____/_____/_____

Check each person(s)/entity below that you approve to receive your Medical Information, if they request.	Description of Information to be Released to this approved person(s)/entity.
❑ **Spouse/Partner** Name: _____________________________	My **Spouse/Partner** may have the following information about my care: □ Complete Health Record □ Financial/Billing Information □ Current Pregnancy Information only □ Other: ____________________________________
❑ **Parent(s)/Guardian(s)** Name: _____________________________ Name: _____________________________	My **Parent(s)** may have the following information about my care: □ Complete Health Record □ Financial/Billing Information □ Current Pregnancy Information only □ Other: ____________________________________
❑ **Other Person(s)/Entity** Name: _____________________________ _____________________________________	The named **person(s)/entity** may have the following information about my care: □ Complete Health Record □ Financial/Billing Information □ Current Pregnancy Information only □ 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:* ______________________________