CAROLINA FOOT & ANKLE ASSOCIATES, PLLC
AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS

Patient Name: _____ **Date of Birth:** _____

Carolina Foot and Ankle is authorized to release protected health information about the above named patient to the entities named below:

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Are we able to leave a voice mail for you? Please indicate the type of information we are able to leave in the voice mail in the section to the right.	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other_____
☐ Other person (s) we may speak to about you. (provide name and phone number) What type of information may we discuss? 1._____ 2._____ 3._____	☐ Financial ☐ Medical ☐ Able to pick up supplies
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Please note that we we participate in NC HealthConnex (North Carolina's state-operated Health Information Exchange). More information about the exchange, including details about how to opt out can be found at hiea.nc.gov/patients

.**Notice of Privacy Practices:** Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing below, you are agreeing that you have had the opportunity to read our notice of privacy practices.

Signature: X_____ **Date:** _____

Patient or Personal Representative