Compound Authorization for Release of Information
Cary Gastroenterology Associates

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays/diagnostic tests ❑ Other_____
❑ Spouse	❑ Financial ❑ Medical as follows: _____
❑ Parent (provide name)_____	❑ Financial ❑ Medical as follows: _____ _____
❑ Other (provide name) _____ _____	❑ Financial ❑ Medical as follows: _____

Clinical Trials: Cary Gastroenterology Associates are active in clinical research trials. Cary Gastroenterology Associates receives remuneration for patients who enroll in the studies. Would you like to be contacted if a clinical trial becomes available that the physician feels may benefit you as a patient?

___ Yes ___ No

I authorize the contracted clinical research staff to review my demographic information and the medical history contained in my medical record in order to determine if I may be a candidate for the clinical trial prior to contacting me regarding my interest in the study.

___ Yes ___ No

Patient Information

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 as described in this document. 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 redisclosure 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 on signing . This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

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

_____

Revised July 2008