Cary Gastroenterology Associates
Authorization for Use and/or Release of Information

Expires upon one time release

Patient Information: **Chart #:**_____

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Name & address of Covered Entity authorized to release information:
Cary Gastroenterology Associates 1000 Crescent Green, Ste. 102 Cary, NC 27518

Please forward/release my health information to:

_____

_____

_____

The information below is provided at the request of the patient. (Describe PHI needed)

_____

_____

The information is requested because:

_____

_____

This authorization shall be in effect until the information has been forwarded as requested.

I understand that I have the right to revoke this authorization at any time by sending a written notification to Cary Gastroenterology Associates and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information 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 inspect or copy the protected health information as described in this document. I can do this by written notification to Cary Gastroenterology Associates

_____ Date _____

Signature of Patient or Personel Representative

_____

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