# Authorization for Release of Information to Family and/or Friends

Name of Patient _____MR#_____Date of Birth _____

**North Carolina Eye, Ear, Nose & Throat, PA** is authorized to discuss my medical care and may release my confidential health information to the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

**Description of information to be released**

_____Any Information
_____Financial Information
_____Family Billing Information
_____Information results from tests or x-rays.
_____Medical information as follows: _____

## Rights of the Patient

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 by sending a written notification to **North Carolina Eye, Ear, Nose & Throat, PA, Medical Records Department, 4102 N. Roxboro Rd, Durham, NC 27704.** 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.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____Date _____
Signature of Patient or Personal Representative

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