Cape Fear Cardiology Associates, P.A.

3634 Cape Center Drive • Fayetteville, North Carolina 28304 • Telephone (910) 485-6470 • FAX (910) 485-8198

Compound Authorization for Release of Information

Patient Name ______________________________ Date of Birth ________________

Account # ______________________________

Cape Fear Cardiology Associates, P.A. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information	Information to be Released
___ Voice Mail/Answering Machine	___ Results of diagnostic tests ___ Information from doctor in direct response to a message regarding above named patient
___ Spouse Name ________________	___ Financial ___ Results of diagnostic tests ___ Information from doctor in direct response to a message regarding above named patient
___ Parent(s) Name(s) ________________	___ Financial ___ Results of diagnostic tests ___ Information from doctor in direct response to a message regarding above named patient
___ Child(ren) Name(s) ________________	___ Financial ___ Results of diagnostic tests ___ Information from doctor in direct response to a message regarding above named patient
___ Other Name ________________	___ Financial ___ Results of diagnostic tests ___ Information from doctor in direct response to a message regarding above named patient

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 Cape Fear Cardiology Associates, P.A. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective from this date 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 in writing by the patient.

____ Date ______________

Signature of Patient or Personal Representative

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

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