NORTH CAROLINA INTERNAL MEDICINE, PC
251 KEISLER DR., SUITE 300
CARY, NC 27518
CHINA K. GOLI, MD & ASWANI NAIDU, MD
TEL: (919) 851-1600 FAX: (919) 851-1666

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

Patient Name: _____ Date of Birth: _____

Entity to receive information:

_____ Leave information on the voicemail / answering machine.

_____ Mail information to my house.

The person(s) listed below are authorized to receive information regarding me:

Name:	Relationship to you:
_____	_____
_____	_____
_____	_____

Description of information to be released to the above authorized entities:

_____ Financial information _____ Billing information

_____ Results of tests (Blood work & Radiology)

_____ Medical information as follows:

_____

_____

_____ Other specified information or restriction of release of information as described:

_____

_____

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 Internal Medicine, PC. I

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understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective from the date of the written notification of revocation forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure 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 authorized representative signing this authorization.

By signing below, I acknowledge that I have read and understand my patient rights and information regarding me will be disclosed within the parameters I defined above.

Patients Printed Name: _____

Patients Signature: _____ Date: _____

If you are signing this authorization as an authorized representative of the patient please provide us with the following:

Name: _____

Relationship to the Patient: _____

Please attach the necessary documentation showing that you are authorized to sign on the patient's behalf.