

HIPAA Authorization for Release of Information To Family and/or Friends

Name of Patient _____ DOB _____

Piedmont Oncology Specialists is authorized to release protected health information about the above named patient in the following manner:

_____ Leave information on voicemail at:

Home Work Cell Phone

_____ Give information to spouse.

_____ Give information to: _____.

Description of information to be released:

_____ Appointment Reminders Cards _____ Medical Information

_____ Financial Information _____ Information results from tests or x-rays.

_____ Other 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 Piedmont Oncology Specialists.

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)