Raleigh Capitol Ear, Nose, and Throat
Authorization for Release of Information and Communication

Patient Name: _____ **Date of Birth:** _____

By law, we are not allowed to discuss your Protected Health Information with **anyone else** without your consent. Is there anyone else with whom we may discuss your protected health information? This also includes making/cancelling appointments for the patient identified above:

(Please circle)

NO you may only discuss my Protected Health Information with me (patient).

YES you may discuss my Protected Health Information with the following people only:

Spouse: _____ **Guardian:** _____

Other(s): _____ _____

You may also find it convenient for our medical staff to utilize voicemail and/or email messages as a means of electronic correspondence with you. To authorize these forms of electronic communication, list any preferred email addresses/phone numbers, and check the box below:

Email Address: _____

Phone Number(s): _____ _____

☐ **For electronic communication**, I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive electronic communication as indicated.

As a service to our patients, we will attempt to remind you of your upcoming appointment(s). We do not discuss or release any information except that you have an appointment, on a certain day, at a certain time.

Patient Rights:

- I have the right to revoke authorization at any time.
- I may inspect or copy the Protected Health Information to be disclosed or described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____

Signature of consent by Patient or Personal Representative Date

Revised Oct 2018