PHYSICIANS EAST
PROVIDING COMPREHENSIVE HEALTH CARE TO EASTERN NORTH CAROLINA

Authorization to Speak to Others

Patient Name: _____ Chart Number: _____ Date of Birth: _____

I, _____, do hereby authorize Physicians East to disclose to the person(s) noted below information relating to my healthcare.

The information which may be shared includes information taken from:
☐ Medical record ☐ Billing record ☐ Other: _____

Medical record information includes information taken from office visit notes, consultation reports, laboratory results, diagnostic reports, procedure reports and radiology reports. I understand information released may be related to HIV/AIDS, communicable/sexually transmitted diseases, drug testing information, mental health, substance and/or alcohol use, treatment for abortion and/or contraceptive management or genetic testing.

Person(s) to whom the above information may be discussed/shared with:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Purpose of authorization: At the request of the individual or ☐ Other: _____

I understand this authorization can be revoked by writing to the Physicians East, P.A. Privacy Officer or filling out a form (Ref. FM0018) at any time, except to the extent that action has been taken in accordance with this authorization. **Unless otherwise revoked, this authorization will be in effect as long as I am a patient at Physicians East.**

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Patient Signature: _____ Date: _____

Personal Representative Signature (if not the patient): _____ Date: _____

Printed Representative's Name: _____ Relationship to Patient: _____

Physicians East Representative Signature: _____ Date: _____

Printed Physician East Representative Name: _____

A Notary Public must witness the patient/personal representative's signature on request not completed at Physicians East.

Notary Public: _____ Date: _____

Sworn to and subscribed before me this _____ day of _____, 20 ____. My commission expires: _____

Revised: 5/2017