Compound Authorization for Release of Information

Name of Patient ____ Date of Birth ____________________________________

I hereby voluntarily authorize and direct Physicians Eldercare, P.A. to disclose information specified below to the recipients listed below.

Recipient to Receive Information. Check each recipient that you approve to receive information.	**Description of information to be released.** Check the information that can be given to the recipient on the left in the same section. Also provide the purpose or need for disclosure to the recipient.
☐ Voice Mail or Answering Machine. List Telephone Number: (____)____________	☐ Results of lab tests/x-rays ☐ Appointment Time ☐ Other__________________________ Purpose or Need for Disclosure: ☐ At the request of the patient. ☐ Other:_________________________
☐ Spouse (provide name) ________________	☐ Billing information ☐ Financial information ☐ Medical Information. Please list: ☐ All of the medical records that Physicians Eldercare, P.A. has in its possession. ☐ All of my medical records except for the following:____________________ ☐ Only the following records or types of health information: _______________ Purpose or Need for Disclosure: ☐ At the request of the patient. ☐ Other:_________________________
☐ Parent (provide name)_________________	☐ Billing information ☐ Financial information ☐ Medical Information. Please list: ☐ All of the medical records that Physicians Eldercare, P.A. has in its possession. ☐ All of my medical records except for the following:____________________ ☐ Only the following records or types of health information: _______________ Purpose or Need for Disclosure: ☐ At the request of the patient. ☐ Other:_________________________
☐ Other (provide name) _________________ __________________________________	☐ Billing information ☐ Financial information ☐ Medical Information. Please list: ☐ All of the medical records that Physicians Eldercare, P.A. has in its possession. ☐ All of my medical records except for the following:____________________ ☐ Only the following records or types of health information: _______________ Purpose or Need for Disclosure: ☐ At the request of the patient. ☐ Other:_________________________
☐ Support Group (provide name)___________	☐ Demographic Information Purpose or Need for Disclosure: ☐ At the request of the patient. ☐ Other:_________________________

Rights of the Patient
I understand that I have the right to revoke this authorization at any time as further described in the Notice of Privacy Practices of Physicians Eldercare, P.A.

I understand that I have the right to inspect or copy the protected health information to be disclosed as described in this authorization by sending a written notification to ________________________.

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 effect until revoked by me in writing.

____ Date ___________________
Signature of Patient or Personal Representative

____
Signature of Patient or Representative

____
Print Name of Representative (if applicable)

Date: ____________________________

Please describe the Representative's authority to act on behalf of Patient (initial one):

( ) The representative is the guardian of the patient, who has been adjudicated incompetent.
( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Physicians Eldercare, PA personnel.

Physicians Eldercare, P.A. requests two witnesses' signature to be obtained when a patient cannot sign or uses an "X" as a signature. Each witness hereby verifies that the patient understands the above and agrees to the content.

______________________________________ ______________________________________
Witness Date Witness Date

OFFICE USE ONLY:

☐ A COPY OF THIS AUTHORIZATION HAS BEEN PROVIDED TO THE PATIENT.