

# Capital Family Physicians, P.A.

2417 Atrium Drive, Suite 201, Raleigh, NC 27607 Ph: (919) 232-0020 Fax: (919) 232-0030

## COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Capital Family Physicians, P.A.* is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**Please check each person or entity that you approve to receive information:**

- Voice mail: \_\_\_\_\_ Work and/or \_\_\_\_\_ Home
- Spouse: (Name) \_\_\_\_\_
- Parent: (Name/s) \_\_\_\_\_
- Other: (Name/s) \_\_\_\_\_

**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 information to be disclosed as described in this document by sending a written notification to *Capital Family Physicians, P.A.*

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 I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_  
Relationship to patient