Consent for Release of Protected Health Information

I consent to disclosure of the following protected health information about me to the family member(s) or person(s) involved in my care or payment for my care referenced below.

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that may apply

___ All my medical information

___ Financial Information

___ Lab or Test Results

___ Information to assist my caregivers

___ Pick up Prescriptions

___ Please check this line to confirm it is acceptable to call your cell or home phone about normal test results. This would include permission to leave a message as well, in those instances when you can't be reached.

My Consent will remain in effect as long as I am a patient of Pinehurst Dermatology unless and until I notify Pinehurst Dermatology in writing of any changes.

_____ or _____

Signature of Patient

Signature of Representative and Relationship

_____ _____

Print Name

Print Name

_____ _____

Date

Date

Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operation purpose defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statue, N.C.G.S 8-53 and HIPAA allow verbal authorization or consent for release of information to family members. This form will serve as formal documentation of the patients intent to whom PHI can be shared and will become part of the Patient's Medical Record.