Authorization for Release of Information
And
Contact Preferences Disclosure

Patient Name: ____ Date of Birth________________

I authorize contact by providers to provide the following information to:

Name	Phone #	Description of Information Released
		☐ Medical ☐ Financial
		☐ Medical ☐ Financial

I authorize contact by provider to myself using the following means:

Cell phone/home phone ________________________________ Can we leave message? ☐ Yes ☐ No

Work phone: ________________________________ Can we leave message? ☐ Yes ☐ No

Email: ____

Can we send you email notices about new happenings at NCCRM? ☐ Yes ☐ No

I authorize NCCRM to disclose information as listed above. I also understand that for email communication, that if information is not sent in an encrypted manner there is a risk it could be accessed and used inappropriately.

Your Rights:

- You can revoke this authorization at any time.
- I may inspect or receive a copy of the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective moving forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosureby the recipient and may no longer be protected by federal or state laws.
- I have the right to refuse to sign this authorization and that may treatment will not be effected on signing.

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

____ ________________________
Patient Signature Date