Albemarle Center for Family Medicine,

a division of Anchor Healthcare, PLC.

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Albemarle Center for Family Medicine is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail Cell Phone_____ Home Phone_____ Work Phone_____	☐ Results of lab tests/x-rays ☐ Prescription Notifications ☐ Return Phone Call Advice ☐ Appointment Reminders Other_____
☐ Spouse (provide name and phone number) _____ _____	☐ Financial ☐ Medical ☐ Emergency Contact Only
☐ Parent / Guardian / Adult Children (provide name and phone number) _____ _____	☐ Financial ☐ Medical ☐ Emergency Contact Only
☐ Email / text communication-Provide email address* _____ ***In order for email / text communication to occur, please accept the disclosure below:**	☐ Financial ☐ Medical ☐ Breach notification ☐ Appointment Reminders
☐ For email and text communications I understand that if such communication is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and text communications.	

Revised August 2013

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy 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 going forward.
- 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 have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Printed Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Date

_____

*Description of Personal Representative's Authority (attach necessary documentation)