**Pinner Clinic, PA**

*A Rich History of Medical Tradition Since 1915*

 **Carroll A. Pinner, III, MD Benjamin C. Pinner, MD Lori Turner, APRN Kelsey Rutter, APRN**

**COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION**

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

|  |  |
| --- | --- |
| If we need to reach **you** during the day, what is the best **daytime** phone number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is this home, work or cell? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OK to leave voice mail messages? □ Yes □ No OK to send text messages? □ Yes □ No | Check the following information that can be provided by voice mail and/or text:* Financial
* Medical Information
* Results of lab tests/x-rays
* Appointment Information
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

***Pinner Clinic, PA*** *is authorized to release protected health information regarding the above-named patient to the entities named below. The purpose of this form is to strictly adhere to patient instructions.*

|  |  |
| --- | --- |
| **Person/Entity to Receive Information**Provide information for eachperson/entity that you approve to receive your information. | **Description of Information to be Released****Check each** that can be given to the person/entity indicated on the left |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Voice mail messages ok? □ Yes □ No  | * Financial
* Medical Information
* Results of lab tests/x-rays
* Appointment information
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best Daytime Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Voice mail messages ok? □ Yes □ No  | * Financial
* Medical Information
* Results of lab tests/x-rays
* Appointment information
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**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 health information to be disclosed as described in this document by sending a written notification to Pinner Clinic, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective moving forward from the date listed on the form. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative (Attach additional information as necessary)

***This form will expire 1 year from the date listed on the form unless noted otherwise by patient. Form expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***