

**Central Carolina Dermatology Clinic, Inc.**  
**Authorization for Release of Information to Family or Friends**

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Central Carolina Dermatology Clinic, Inc. is authorized to release  
protected health information to the family and/or friends listed below:**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Description of information to be released:**

- All information or
- Financial
- Medical information
- Pathology results
- Test results
- Other information as described: \_\_\_\_\_

**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 the Privacy Officer of Central Carolina Dermatology Clinic. 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 information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient 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 this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

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

**Signature of Patient or Personal Representative**

Attach documentation of Personal Representative's Authority