



# Carolina Digestive Diseases

## & ENDOSCOPY CENTER

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### Release of Information Patient Authorization for CDD to Release PHI to Another Location

By signing this authorization, I authorize Carolina Digestive Diseases, PA to disclose certain protected health information (PHI) about me to \_\_\_\_\_ for the purposes of continuity of care.

This authorization permits Carolina Digestive Diseases, PA to disclose to \_\_\_\_\_, the following specifically detailed description of PHI:

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

This authorization will expire in 90 days unless otherwise noted. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that Carolina Digestive Disease, PA has acted in reliance upon this authorization. My written revocation must be submitted to Carolina Digestive Diseases, PA's Privacy Officer at 704 WH Smith Blvd, Greenville, NC, 27834.

Signed by:	_____	_____
	Signature of Patient/Guardian	Relationship to Patient
	_____	_____
	Patient's Name	Date
	_____	_____
	Print Name of Patient/Guardian	Date of Birth