Pennington Primary Care & Med Spa

Skin Care, Laser and Weight Loss Clinic

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient____ **Date of Birth**_______________________

Carolina Plastic Surgery, dba Crawford Med Spa & Weight Loss Clinic is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information. Ck each person/entity that you approve to receive info.	**Description of information to be released.** Check each that can be given to person/entity
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Appointment reminders ☐ Other
☐ Give information to school ☐ Give information to employer	☐ Appointment absentee information
☐ Spouse	☐ Family billing information ☐ Financial ☐ Medical as follows:
☐ Parent (Provide name)	☐ Family billing information ☐ Financial ☐ Medical as follows:
☐ Other (Provide name)	☐ Financial ☐ Medical as follows:
☐ *Email (Please provide email address below) ☐ *Text (Please provide phone number below) * In order for email and text communication to occur, you must accept the disclosure below:	☐ Appointment reminders ☐ Financial ☐ Medical ☐ Other

☐ For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

TO GRANT US PERMISSION TO USE YOUR PHOTO ON OUR WEBSITE OR OTHER SOCIAL MEDIA PAGES, PLEASE CHECK THE SECTION BELOW

☐ Photo of patient provided by patient	☐ May be posted in office
☐ Photo of patient taken by staff	☐ May be posted on website and/or other social media pages
☐ Other (Provide name)	☐ Other

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

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Signature of Patient or Personal Representative Date