



COMPOUND AUTHORIZATION

Patient Name: _____ **MRN #:** _____
Date of Birth: _____ **Today's Date:** _____

Patient Communications

Home Phone: _____ Acceptable to leave message: ☐ Yes ☐ No
Cell Phone: _____ Acceptable to leave message: ☐ Yes ☐ No Email: _____

☐ I do not wish to designate other persons/entities to receive my health information on my behalf.

☐ I wish to grant permission to Cary Cardiology, PA to release the below checked information to the persons/entities indicated below.

☐ Spouse/Significant Other (please provide names): _____

☐ Financial/billing information **Communication:** Home Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Medical information as follows: Cell Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Labs ☐ Diagnostic Tests ☐ Appointments ☐ General medical information/condition

☐ Parent/Family Member/Other (please provide name/relationship): _____

☐ Financial/billing information **Communication:** Home Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Medical information as follows: Cell Phone: _____ Acceptable to leave message ☐ Yes ☐ No

☐ Labs ☐ Diagnostic Tests ☐ Appointments ☐ General medical information/condition

☐ Employer/Workers' Compensation (please provide name): _____

☐ Information about return to work and/or work restrictions, and any absences that result from appointments.

Contact Information: Phone: _____ Fax: _____

☐ School (please provide name): _____

☐ Information about any absences that result from appointments

☐ Activity Restrictions

Contact Information: Phone: _____ Fax: _____

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that the information has already been released pursuant to this authorization. Otherwise, this authorization will continue to be valid for one year.

Patient/ Representative Signature: _____ **Date:** _____

Witness: _____ ☐ Patient unable to sign

Revocation/Amendment
Name/Signature: _____ **Date:** _____