CarolinaDigestiveDiseases
& ENDOSCOPY CENTER
Phillip J. Goldstein MD ● Maurice Marcuard MD ● Lindsay Roebuck FNP-C
Tel: 252-758-8181 ▪ Fax 252-758-8182

Patient Authorization for CDD to Obtain Protected Health Information

By signing this authorization, I authorize _____

To disclose certain protected health information (PHI) about me to Carolina Digestive Diseases, PA, for the purposes of continuity of care.

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

_____

_____

_____

Please fax all information to the secure fax number listed above.

This authorization will expire in 90 days unless otherwise noted. When this 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 Diseases, PA has acted in reliance upon this authorization. My written revocation must be submitted to Carolina Digestive Diseases, PA's Privacy Officer at 704 W.H. Smith Boulevard, Greenville, NC 27834.

Signed by: _____ _____

Signature of Patient/Guardian | Relationship to Patient

_____ _____

Patient's Printed Name | Date

_____

Date of Birth