CarolinaDigestiveDiseases
& ENDOSCOPY CENTER
Phillip J. Goldstein MD ● Maurice Marcuard MD
Tel: 252-758-8181 · Fax 252-758-8182

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 HIPPAA 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