**Carolina Cardiology Sleep & Obesity Center, PC**

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**3280 Henderson Drive Suite C Jacksonville, NC 28546**

**Phone: (910) 915-8450 - Fax: (888) 745-7026**

**PATIENT AUTHORIZATION FORM**

Authorization to Release Information to:

Many of our patients allow family members such as their spouse, significant other, parents or children to

call and request the result of tests, procedures and financial information. Under the requirements for HIPAA

we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your

medical information, any diagnostic test results and/or financial information released to any family members

you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in

reliance on your prior consent.

I authorize Carolina Cardiology Sleep & Obesity Center to release my records and any information requested to the following individuals.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (PLEASE PRINT)

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Signature

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

Date

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