Designated Party Release

Complete Primary Care
Division of High Rock Internal Medicine, PA
1215-C West Clemmonsville Rd
336-300-8855

You may give **Complete Primary Care a Division of High Rock Internal Medicine, PA** written authorization to disclose your protected health information to anyone that you designate, such as a family friend or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone or another party that you designate.

Patient Name: _____ Date of Birth: _____

Date: _____ Account#_____ Chart#_____

At my request, I authorize **Complete Primary Care a Division of High Rock Internal Medicine, PA** to disclose my protected health information to:

Name: _____ Phone#:_____

Name: _____ Phone#:_____

Name: _____ Phone#:_____

At my request, I also authorize **Complete Primary Care a Division of High Rock Internal Medicine, PA** to communicate my protected health information via the following methods:

____ Leave detailed message on my home answering machine (phone#_____)

_____ Leave a detailed message on my voice mail at work (phone#_____)

_____ Leave a detailed message on my cell phone voice mail (phone#_____)

_____ Fax detailed medical information (fax #_____)

Authorized Signature: _____ Date_____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any action **Complete Primary Care a Division of High Rock Internal Medicine, PA** took in reliance on this authorization before receipt of written notice of cancellation.

Signature authorizing Cancellation: _____

Date of Cancellation: _____
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