CAROLINA SURGERY & CANCER CENTER, PLLC

advanced personal care close to home

HIPAA PATIENT PRIVACY FORM

CAROLINA SURGERY & CANCER CENTER - 1501 TATE BLVD SE, SUITE 202 - HICKORY, NC
TELEPHONE 828-485-2707 FAX 828-485-2708

I, _____ hereby authorize CAROLINA SURGERY & CANCER CENTER (Dr. R. Locke, Dr. B. McCluer & Dr. S. Pabst) and staff to give the following people information concerning my health, treatment, billing, and/or insurance information.

Spouse: _____

Significant Other: _____

Other: _____

Other: _____

Other: _____

THE FOLLOWING INFORMATION MAY BE GIVEN TO THE ABOVE INDIVIDUALS:

_____ Appointment time

_____ Bill / Statement

_____ Medications

_____ Any information regarding my health

_____ MESSAGES MAY BE LEFT ON MY ANSWERING MACHINE AND/OR VOICEMAIL

PLEASE NOTE: WE WILL NOT BE ABLE TO SPEAK TO ANYONE NOT LISTED ON THIS CONSENT

I understand that I may terminate this consent at any time by giving written notice to CAROLINA SURGERY & CANCER CENTER. Any changes to this form will require a new consent form to be completed, signed and dated:

SIGNED: _____ Date: _____
(Patient / Parent / Legal Guardian)

WITNESS: _____ Date: _____