Cardiovascular Center, P.A.
Dr. M. R. Lakshmi Narasimhan M.D.
264 Memorial drive Jacksonville, NC 28546
Phone: (910) 455-7001 Fax: (910) 455-9778 Phone: 910) 455-0578

Compound Authorization for Release of Information

Name of Patient _____ DOB: _____
Cardiovascular Center, PA is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patients instructions.

Entity to Receive Information:
Check each person/entity that you approve to receive

- ☐ Voice Mail
- ☐ Give information to employer
- ☐ Give information to school
- ☐ Spouse (provide name) _____
- ☐ Parent (provide name) _____
- ☐ Other (provide name) _____
- ☐ Support Group (provide name) _____

Rights of the Patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be described in this document by sending a written notification to: **Cardiovascular Center, PA 264 Memorial Drive, Jacksonville, NC 28546**

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____
Patient Name (Please print)

_____ Date: _____
Patient Signature