HIPAA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Care Information:

I give consent to the staff at Gaston Medical Group, PA to communicate with the person(s) listed below regarding my medical treatment. I consent to the use of my protected Health Care Information when communicating with the person(s) below. Gaston Medical Group, PA may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Gaston Medical Group, PA in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Signature _____Date_____

PLEASE LIST NAMES OF PERSONS OR FAMILY
YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

NAME_____ Relationship to Patient_____

NAME_____ Relationship to Patient_____

NAME_____ Relationship to Patient_____

NAME_____ Relationship to Patient_____

NAME_____ Relationship to Patient_____

E-MAIL ADDRESS: _____
****(For future newsletters)****