

**ADDENDUM TO PRIVACY PRACTICES
PERMISSION TO SHARE INFORMATION**

Name of Patient: _____ Date of Birth _____

Carolina Orthopedics and Sports Medicine 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 patient's instructions.

Consent to Communicate with Persons Listed

Name	DOB	Relationship	Consent to Release Information
			Basic Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Financial <input type="checkbox"/> Yes <input type="checkbox"/> No
			Basic Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Financial <input type="checkbox"/> Yes <input type="checkbox"/> No
			Basic Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Financial <input type="checkbox"/> Yes <input type="checkbox"/> No
			Basic Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Financial <input type="checkbox"/> Yes <input type="checkbox"/> No

Consent to Method of Communication

Method	Preferred	OK to leave Voicemail?	Best Time to Call
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Email Appt Reminders	<input type="checkbox"/>	<input type="checkbox"/> Email Medical Info	<input type="checkbox"/> Email Marketing Info
<input type="checkbox"/> Text Appt Reminders	<input type="checkbox"/>	<input type="checkbox"/> Text Marketing Info	<input type="checkbox"/> Send Regular Mail

Patient Information

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 disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the 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 in writing.

X _____

DATE: _____

Signature of Patient or Personal Representative
Description of Personal Representative's Authority