Designated Party Release

High Rock Internal Medicine, P.A.
104 West Medical Park Drive
(336) 224-0931

You may give **High Rock Internal Medicine, P.A.** written authorization to disclose your protected health information to anyone that you designate, such as a family member 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 **High Rock Internal Medicine, P.A.** to disclose my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name:_____ Phone #: _____

At my request, I also authorize **High Rock Internal Medicine, P.A.** to communicate my protected health information to me via the following methods:

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

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

☐Leave 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 **High Rock Internal Medicine, P.A.** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____