Compassionate Care
Leslie A. Smith, M.D.
400 Shadowline Drive
Suite 201B
Boone, NC 28607
Phone: 828-832-8300 Fax: 828-832-8303

HIPPA AUTHORIZATION FORM

(permissions from patient/patient's legal guardian to share personal medical information)

Patient Full Name: _____
Date of Birth: _____
Mailing Address: _____
City, State, Zip: _____
Email Address:_____
Emergency Contact: _____

I, _____, hereby authorize Compassionate Care (Dr. L. Smith) to release any and all medical information and test results that pertain to me to the following individual(s):

Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____
Name: _____ Phone #: _____Relationship _____

Is it okay to leave messages on your answering machine in the event that you do not answer your phone? _____ (Initial if yes)

I authorize Compassionate Care to contact the individual(s) listed above to convey any pertinent information about me in the event that I am unable to be reached. I understand that I may revoke/cancel this authorization or by notifying Compassionate Care in writing of my intent to revoke or change the name(s) of the individuals to whom information is to be released.

Signature of Patient or Legal Guardian: _____
Date: _____

Received by (Office use only): _____