CAROLINA SURGERY
& CANCER CENTER, PLLC

advanced personal care close to home

HIPPA PATIENT PRIVACY FORM

CAROLINA SURGERY & CANCER CENTER - 1501 TATE BLVD SE, SUITE 202 - HICKORY, NC
TELEPHONE 828-485-2707 FAX 828-485-2708

I, ____ hereby authorize CAROLINA SURGERY & CANCER CENTER (Dr. R. Locke, Dr. B. McCluer & Dr. S. Pabst) and staff to give the following people information concerning my health, treatment, billing, and/or insurance information.

Spouse: ____

Significant Other: ____

Other: ____

Other: ____

Other: ____

THE FOLLOWING INFORMATION MAY BE GIVEN TO THE ABOVE INDIVIDUALS:

__________ Appointment time

__________ Medications

__________ Any other information regarding my health

__________ Test/Lab, X-ray results

__________ Procedures

__________ Bill / Statement

__________ MESSAGES MAY BE LEFT ON MY ANSWERING MACHINE AND/OR VOICEMAIL

I understand that I may terminate this consent at any time by giving written notice to CAROLINA SURGERY & CANCER CENTER. Any changes to this form will require a new consent form to be completed, signed and dated:

SIGNED: ________________________________ Date: ________________________________
(Patient / Parent / Legal Guardian)

WITNESS: ________________________________ Date: ________________________________