Marlboro-Chesterfield Pathology, P.C.

30 Page Street, Pinehurst, N.C. 28374
PO Box 4270, Pinehurst, N.C. 28370
910-687-4188
910-235-0171 fax

CONSENT FOR RELEASE OF INFORMATION

Name of Patient: _____

MARLBORO-CHESTERFIELD PATHOLOGY is hereby authorized to release to:

_____
Agency or Individual Receiving information

the following information or documents:

_____

to be used in connection with the following purpose or need: _____

_____

I hereby release MARLBORO-CHESTERFIELD PATHOLOGY and its agents and employees from any and all liabilities and responsibilities, and damages and claims which might arise from the release of information authorized above. I acknowledge that this consent is valid for ninety (90) days or until _____ 20____. I further understand that I can withdraw this consent for release at any time prior to its expiration.

_____ _____
Date Signature of Patient

_____ _____
Date Witness

Special circumstances which necessitate other than patient's signature:

_____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT SUFFICIENT for this purpose. An oral disclosure may be accompanied or followed by such a notice.