Authorization to Release Health Information

Patient Name:______________________________ Date of Birth:______________________

Address/Phone Number:____

1. I authorize Medical Oncology Hematology Consultants to use or disclosure of the above-named individuals confidential health information as described below.
2. Information to be used or disclosed covering the following dates or periods _______ to _______.
3. The type and amount of information to be used or disclosed is as follows (please circle):
   a. Flow sheets (basic history, medications, allergies, vital signs, lab results summary)
   b. Progress notes of Medical Oncology Hematology Consultants
   c. Laboratory/pathology reports (reports only; MOHC does not have slides or specimens; must contact facility where this was done)
   d. X-ray/diagnostic reports (reports only; MOHC does not have films – must contact facility where studies done)
   e. Chemotherapy/injections/medication records
   f. Correspondence (including records from other facilities, copies of forms sent and received)
   g. Hospital records (copies only of limited records; must contact hospital for complete set of records)
   h. Phone messages
   i. Consents
   j. Billing records
   k. Entire record (including demographics, insurance)
   l. Other____
4. I understand that the information in my health record may include sensitive information, including information relating to sexually-transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to the following:
   ____
   ____
   for the purpose of____
6. This authorization will expire in six (6) months unless otherwise specified.
7. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my revocation to the medical records custodian of Medical Oncology Hematology Consultants. I understand that the

revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim un my policy.

8. I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand the disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer at Medical Oncology Hematology Consultants.

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Signature of Patient or Patient's Representative/Date

____ ________________________

Printed Name of Patient or Patient's Representative Relationship