Medical Oncology Hematology Consultants, PA
Helen F. Graham Cancer Center, Suite 3400
4701 Ogletown-Stanton Road
Newark, DE 19713-2055
302-366-1200 FAX: 302-366-1700

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name ______________________________ Date __________________

Please **REQUEST** Medical Information **FROM**:

____
Person/Organization Name

____
Address

____
City, State, Zip Code

____
Phone Number Fax Number

Please **SEND** Medical Information **TO**:

____
Person/Organization Name

____
Address

____
City, State, Zip Code

____
Phone Number Fax Number

I hereby authorize ____________________________ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The health information will be released and/or disclosed for the following purpose(s):

☐ Treatment/Continuing Medical Care (e.g., Other Healthcare Providers, Hospital, Physicians)	☐ Legal purposes (e.g., Attorneys)	☐ Personal Use
☐ Billing or Claims	☐ Insurance (e.g., life insurance application)	☐ Disability Determination
☐ School	☐ Employment	☐ Other, please specify:

Check the box which type of information is to be released and/or disclosed:

☐ General Medical Information (from ____________ to ____________)
☐ Information regarding Specific Treatment (from ____________ to ____________)
☐ Lab Results (from ____________ to ____________)
☐ Other, please specify: ____
☐ Entire medical record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).

This authorization expires on/upon ____
(Insert date or event that triggers expiration)

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.

I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

______________________________ ______________________________
Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

______________________________ ______________________________
Name of Personal Representative Relationship to Patient

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Health Information Access Request Form

You have the right to inspect and copy your health information, which is kept in a designated record set, because it may be used to make decisions about your health care. Usually, this includes medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances.

Please indicate, specifically, the information to which you are requesting access:

____

____

Please indicate the form or format in which you would like to receive your requested information:

____

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, email, on-site, etc.), and provide the necessary phone number or address:

____

We may impose a fee of $__________ to cover the cost of copying the requested information or postage when you have requested a copy of the information be mailed to you. Do you agree to these fees? _____ YES _____ NO

______________________________ ______________________
Patient Name Patient Account Number

______________________________ ______________________
Signature Date

____
Name of Personal Representative (if appropriate)

____
Signature of Personal Representative (if appropriate)

For (Practice Name) Use Only:
Date Received: ______________________ _____ Accepted _____ Denied

If denied, check reason for denial:
_____ Excepted Information _____ Inmate Request _____ Confidentiality Issues
_____ Research _____ Privacy Laws _____ Other: ____________

Date and method of informing individual of original decision: ______________________
If denied, was review requested? _____ Yes _____ No

Name of reviewing official: ______________________ Decision on review:__________

Date and method of informing individual of review decision: ______________________
Comments:____

______________________________ ______________________
Staff Member Signature Date

6/2022 LL