AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information/Protected Health Information (P.H.I.)

PATIENT'S NAME ______________________________
Last First M.I.

ADDRESS ______________________________

BIRTH DATE _____/______/______ **DAYTIME PHONE NUMBER** _______________ **SS #** _______________
Month Day Year

ORGANIZATION PROVIDING INFORMATION		ORGANIZATION REQUESTING INFORMATION	
Name of person or organization releasing information		Name of person or organization releasing information	
Street Address, City, State, Zip		Street Address, City, State, Zip	
Phone	Fax	Phone	Fax

INFORMATION TO BE DISCLOSED

☐ All Medical Records ☐ Medical Notes/Summary ☐ Operative/Procedure Reports ☐ All Lab Reports ☐ Diagnostic Imaging Reports
☐ Radiation Therapy Reports ☐ Patient Demographic Information (name, address) ☐ Other______________

Purpose of Disclosure______________

This is a ☐ One-Time Disclosure ☐Continuous disclosure for 12 months beginning____________, ☐ Or Other:____________

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:

☐ HIV/AIDS related information and/or records ☐ Mental Health information and/or records
☐ Sexually Transmitted diseases ☐ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: ______________________________ **DATE:** ______________
Patient or legal representative

RIGHT TO REVOKE AUTHORIZATION

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION.

Authorized Copy Received: ☐

AUTHORIZATION & SIGNATURE

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release **Integrated Community Oncology Network, LLC** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient:______________________________ Date:______________

Patient Signature:______________________________ Social Security #:______________

Printed Name of Parent, Guardian or Legal Representative:______________________________

Parent, Guardian or Legal Representative Signature:______________________________

Relationship to Patient:______________________________

Sent by: ☐Fax (Patient must initial approval) ☐ Mail (patient will pick up) Date Records are needed:______________