

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be read, dated, and signed by the patient or by a person authorized by law to give authorization on behalf of the patient.

I, _____, born _____,
(Patient's legal name – First, Middle Initial, and Last) (Patient's D.O.B. Month/Day/Year)

hereby authorize to:

OBTAIN Health Information FROM:

(Name of sending person /entity)

(Clinic / Hospital Name)

(Street / Box)

(City / State / Zip)

(FAX #) / (PHONE #)

SEND Health Information TO:

(Name of receiving person / entity)

(Clinic / Hospital Name)

(Street / Box)

(City / State / Zip)

(FAX #) / (PHONE #)

By **initialing** the spaces below, I specifically authorize the release of the following health information:

_____ Office chart notes incl. History & Physicals
_____ Laboratory reports
_____ Pathology reports
_____ Medication Flow sheets incl. known allergies

_____ Radiation Therapy Logs, notes or records
_____ Consultation Notes
_____ Diagnostic imaging reports
_____ Operative/ Procedure reports

_____ Other _____

I understand that federal or state laws may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information. **By initialing the spaces below, I specifically authorize the release of the following health information:**

_____ **HIV/AIDS** related records including HIV testing

_____ **MENTAL HEALTH** information

_____ **DRUG/ALCOHOL** diagnosis, treatment or referral information

_____ **GENETIC TESTING** information (which may include testing to determine the characteristics of tumor)

I understand that my health information may be re-disclosed by the person or entity receiving my health information from Compass Oncology and that it may no longer be protected under federal or state laws.

I understand that the health information will be used for _____
(List stated purpose – **be specific**)

I voluntarily sign this authorization and I understand that my ability to obtain health care from Compass Oncology will not be affected if I refuse to sign this authorization.

This authorization expires on: _____
(Please specify the date or an event that triggers the expiration) (event) (exp date)

I understand that I may revoke this authorization at any time by notifying Compass Oncology in writing, and that my revocation is not effective to the extent that Compass Oncology has acted in reliance on this authorization. This authorization will expire 180 days from the date of signing or on the expiration date or event specified, if earlier.

Signature of Patient or Person Authorized by Law to Act on Patient's behalf

Today's Date

If this authorization is signed by a person authorized by law to act on behalf of a patient, please describe your relationship to the patient: _____