



# Authorization TO RELEASE MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Account Number: \_\_\_\_\_ Physician: \_\_\_\_\_

**I CONSENT TO RELEASE OF MEDICAL INFORMATION (RECORDS)**

TO  FROM: Hematology Oncology, Associates, P.C.

TO  FROM: \_\_\_\_\_

**INFORMATION TO BE RELEASED**

Standard (problem list, medication summary, progress notes, health history, x-ray, laboratory and other tests, immunization records, letters) \_\_\_\_\_

X-ray report(s) and date(s) \_\_\_\_\_

Laboratory and pathology report(s) and date(s) \_\_\_\_\_

Other tests or studies(s) and date(s) (list type of study) \_\_\_\_\_

Other (specify) \_\_\_\_\_

**IN ADDITION, I FURTHER AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION IF IT IS CONTAINED IN MY MEDICAL RECORD: (INITIAL IF RELEASE IS AUTHORIZED)**

\_\_\_\_\_ Drug and alcohol abuse

\_\_\_\_\_ Mental health

\_\_\_\_\_ Information related to diagnosis/treatment of HIV and/or AIDS (special consent form is required)

\_\_\_\_\_ Genetic Testing

**PURPOSE OF DISCLOSURE:** \_\_\_\_\_

THIS AUTHORIZATION IS VALID FOR SIX MONTHS AFTER THE DATE OF SIGNATURE. The authorization may be revoked at any time (but not retroactive to a release of information made in good faith) by the undersigned by providing written notice of revocation.

**REQUIRED:** I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Hematology Oncology Associates, P.C. or you. This information may not be protected by Federal privacy regulation.

DATE \_\_\_\_\_ SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE \_\_\_\_\_

WITNESS \_\_\_\_\_

**BARNETT OFFICE** | 2828 E. BARNETT ROAD | MEDFORD, OR 97504

**PROVIDENCE CANCER CENTER** | 940 ROYAL AVENUE, SUITE 100 | MEDFORD, OR 97504

**THREE RIVERS MEDICAL PLAZA** | 520 S.W. RAMSEY AVENUE, SUITE 201 | GRANTS PASS, OR 97527

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**MEDICAL RECORDS FAX** | 541-608-6674