ONCOLOGY SPECIALISTS OF CHARLOTTE, PA

Authorization for Release of Health Information

PATIENT NAME: _____

DOB: _____/_____/_____ PHONE #: _____

PURPOSE OF DISCLOSURE:

□ Legal □ Personal use □ Physician Request
□ Changing Physicians □ Insurance □ Other: _____

FROM:

_____
_____
_____
_____
_____

TO:

ONCOLOGY SPECIALISTS OF CHARLOTTE, PA
2630 E. 7TH STREET, SUITE 210
CHARLOTTE, NC 28204
Phone: 704-342-1900
Fax: 704-377-0353

SPECIFIC INFORMATION TO BE RELEASED (Example: Office Visit Notes, Laboratory Repots, etc.)
Note: As to what may be released, it will be at the medical offices discretion. The amount reasonably necessary for certain identified purposes, pending purpose of disclosure.

_____

_____

DATES OF SERVICE RANGE: FROM ____/____/____ **TO** ____/____/____

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include final findings, diagnosis, treatment, assessment, dates of service, psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you. I understand that this authorization will expire 90 days from the date of signature.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____ _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE RELATIONSHIP TO PATIENT

NOTICE TO PATIENTS: The patient or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed.

Return completed and signed form by fax 704-377-0353; or mailing to the address listed; or in person during office business hours.