Authorization to Release Health Information

Patient Information:

Name of Patient: ________________________________ Date of Birth: ____________________

Address: ____

City, State, Zip: ________________________________ Phone: _________________________

Oncology Specialists of Charlotte, PA may release the following information:

☐ Entire record ☐ Financial records ☐ Office visit notes
☐ Other______________________ ☐ Diagnosis/Studies

Entity or person who will receive the information:

Name: ____

Address: ____

City, State, Zip: ________________________________ Phone: _________________________

☐ **Send the information electronically. Email address:** ________________________________

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ______________________________________ Date: _
____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ______________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)