ONCOLOGY SPECIALISTS OF CHARLOTTE

A Partner of OneOncology

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:** _____

☐ **Send the Information via Fax. Fax #** _____

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: _____

Print Name of signature above:_____

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)