

**THE CENTER FOR CANCER AND BLOOD DISORDERS
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Account Number _____

Date of Birth _____ SSN: _____

I authorize TEXAS CANCER CARE to disclose the above named individual's health information for the purpose of continued care, claims processing or other related needs.

I understand that unless I mark specific components below, my entire record will be released as needed.

Please release the following:

_____ Problem List	_____ X-Ray Imaging Reports-from (date) _____ to (date) _____
_____ Progress Notes	_____ X-Ray Films
_____ History/Physical Exam	_____ Laboratory Results-from (date) _____ to (date) _____
_____ Medication List	_____ EKG Reports
_____ Immunization Record	_____ Genetic Testing Information
_____ List of Allergies	_____ Other Diagnostic Reports (Specify) _____
_____ Hospital Records	
_____ Other (Specify) _____	

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will continue indefinitely.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Cindy Glickman, Privacy Officer at 817-333-0144 or cglickma@txcc.com. A photocopy or fax of this authorization is as valid as this original.

Signature of Patient or Legal Representative

Date

Relationship to Patient (if Legal Representative)

Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Cancer Care liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to patient (if Legal Representative)

Witness

Date request completed _____ # pages copied _____ Reviewed only _____ Initials _____