AUTHORIZATION FOR RELEASE OR REQUEST OF PROTECTED MEDICAL INFORMATION FROM MEDICAL RECORD(S) FOR SPECIFIED ORGANIZATIONS AND/OR PEOPLE

REQUEST FOR INFORMATION (ONLY THE PATIENT OR PATIENT'S LEGAL REPRESENTATIVE MAY CONSENT TO THE FOLLOWING):

ORGANIZATION PROVIDING INFORMATION	ORGANIZATION REQUESTING INFORMATION
Name: ____________________	Name: ____________________
Address: ____________________	Address: ____________________
Phone: (______) ____________ Fax: (______) ____________	Phone: (______) ____________ Fax: (______) ____________
Name: ____________________	Name: ____________________
Address: ____________________	Address: ____________________
Phone: (______) ____________ Fax: (______) ____________	Phone: (______) ____________ Fax: (______) ____________

INFORMATION TO BE DISCLOSED SHALL INCLUDE ALL MEDICAL RECORDS UNLESS INDICATED OTHERWISE BELOW:

If any box is selected below, only those records indicated should be provided.

☐ Medical Notes/Summary	☐ All Lab Reports	☐ Dates From: ____________ To: ____________
☐ Radiation Therapy Reports	☐ Diagnostic Imaging Reports	☐ Other:
☐ Operative/Procedure Reports	☐ Patient Demographic Info. (name/address)	☐ Other:

Records requested to be sent by: ☐ **FAX (Patient must initial approval)** ☐ **PRINTED (Patient will pick up)** **Date Records are needed:** ____________

SPECIAL AUTHORIZATION TO DISCLOSE PROTECTED CONFIDENTIAL INFORMATION

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH/GENETIC RECORDS are protected by Federal Regulation 42 CFR, Part 2 and/or state law. Release of such records requires specific consent from you. By signing this document I hereby grant Cancer Specialists of North Florida such specific consent as indicated below. **I UNDERSTAND** that my records are protected under federal and/or state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted disease, acquired immune deficiency syndrome (AIDS), Human immunodeficiency virus (HIV) infection, and/or genetic analysis and testing.

AS PART OF THE MEDICAL RECORDS LISTED ABOVE, I DO NOT WANT THE FOLLOWING INFORMATION RELEASED:

☐ Drug, Alcohol or Substance Abuse	☐ HIV/AIDS related information and/or records	☐ Mental health information and/or records
☐ Genetic information and/or records	☐ Hospitalizations (Admission/Discharge/Diagnosis)	☐ Sexually transmitted diseases

IF ANY BOX IS MARKED, I UNDERSTAND THAT MY COMPLETE RECORD MAY BE GIVEN TO ME SO THAT I MAY REVIEW AND SEND THE SPECIFIC RECORDS REQUESTED TO THE RECEIVER OF INFORMATION. I FURTHER UNDERSTAND THAT A DISCUSSION WITH THE OFFICE MANAGER OR REPRESENTATIVE MAY BE REQUIRED.

RIGHT TO REVOKE AUTHORIZATION

I understand that I may revoke this continuous authorization at any time by submitting a new copy of this form to Cancer Specialists of North Florida with the exclusions marked in the above "Special Authorization to Disclose Protected Confidential Information" section. I further understand that I have a right to receive a copy of this authorization if requested. This form is invalid if modified.

AUTHORIZATION & SIGNATURE

I hereby authorize the disclosure or use of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, health care operations, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the related information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Cancer Specialists, LLC from all liability arising from this discloser of my health information. I understand and agree that I am financially responsible for the following fees associated with my request (s): copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

PATIENT NAME: ______________________ **PATIENT DATE OF BIRTH:** ______________ **DATE:** ____________

SIGNATURE OF PATIENT OR LEGAL REPRESENTIVE: ______________________ **RELATIONSHIP:** ____________

REASON PATIENT DID NOT SIGN: ______________________ **Translator ID:** ____________

WITNESS SIGNATURE: ______________________ **DATE:** ______________________