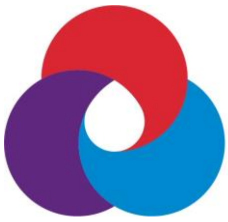

THE CANCER & HEMATOLOGY CENTERS

Authorization Release of Medical Information

Patient Name:____Date of Birth:___/____/____

Address:____

City:______________________________ State:_________ Zip:___________________

Records May Be Released From:

☐ CHC:
☐ Outside Facility: _____________________

____

____

Records May Be Released To:

☐ Self:
☐ CHC:
☐ Outside Facility: ________________________

____

Information Requested: *NOTE: Only documents ordered by CHC Physicians will be disclosed*

☐ MAR/Nurse Notes
☐ Pathology Reports
☐ All
☐ Laboratory Reports
☐ Procedure Notes
☐ Radiology Reports
☐ Office Visits
☐ Billing Statements
☐ Psychotherapy Notes

Dates of Service:____/_____/_____ to ____/_____/_____

Purpose of Disclosure: *NOTE: Required for record being released to anyone other than the patient*

☐ Patient Request
☐ Attorney/Legal
☐ Continued Patient Care
☐ Insurance
☐ Other (Specify)_______________

____

Expiration: *This authorization lasts for 2 years after the date you sign unless otherwise specified.*

Desired Expiration Date:_____/______/______

- This authorization may be cancelled in writing at any time. A cancellation will not change released that occur before receipt of cancellation.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Your signature indicates that you have read and understand this form and authorize the release of your information as described above.

___________________________________ ____/____/____ ______________________________

Patient/Legal Guardian Signature Date Relationship to Patient