File only? __Yes __No

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ Date of Birth: _____

Mailing Address: _____

Phone Number:_____ MRN: _____

I authorize_____ to disclose to: _____

Address: _____

City, State, Zip: _____ Phone:_____

Contact/Relationship:_____ Fax: _____

Method of disclosure: ☐Mail ☐Pick up ☐Portal ☐Fax ☐Email: _____

Purpose of disclosure: ☐Continuity of Care ☐Insurance ☐Personal ☐Legal ☐Other: _____

Dates of Treatment: From:_____ To: _____

Specific reports to be disclosed:

□ History & Physical
□ Progress Notes/Follow-up Notes
□ Discharge Summary
□ Laboratory Reports
□ Radiology Reports
□ Pathology Reports
□ Operative/Procedure Reports
□ Consultation Reports
□ Hospital Records
□ Abstract (Physician notes, most recent labs/radiology, all pathology)
□ Other (Specify): _____

I give specific authorization to disclose the following information as well as documents that contain reference to:

□ HIV test results
□ Drug and alcohol abuse treatment records
□ Documentation of AIDS diagnosis
□ Psychiatric/Mental Health treatment records

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Austin Cancer Center in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

This authorization expires in one year unless revoked earlier, or I specify another time: _____.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____

Signature of Patient (or Patient Representative) Date

_____ _____

Printed Name of Patient (or Patient Representative) Authority of Representative to act for Patient

ACC Health Information Management

Email: releaseofinfo@austincancercenters.com

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