AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for: (**Please Print Clearly**)

_____ _____ _____/_____/_____
Last Name MI First Name Maiden/Other Name Date of Birth

_____ _____
Phone# Address City State Zip

Date(s) of service requested: _____/_____/_____ - _____/_____/_____
From To

Release the medical information from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Disclose the medical information to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Requested medical information authorized to be released: (check items authorized to be released)

- ☐ Consult/H&P
- ☐ OP Report/Procedure Report
- ☐ Follow-up notes
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Weekly CBC reports
- ☐ PSA scores
- ☐ All Labs
- ☐ Tumor Markers
- ☐ Pathology Reports
- ☐ Pathology Slides
- ☐ EKG
- ☐ All CT scans /X-rays /Ultrasound
- ☐ Mammograms
- ☐ Radiotherapy Treatment Records
- ☐ Entire Chart
- ☐ Chemotherapy Flow Sheet
- ☐ Other _____

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I permit information of this type, if it exists, to be released. I understand that **IF** I do check the box, _____ will release such information about me if it exists.

- □ HIV/AIDS infection
- □ Treatment for alcohol and/or drug abuse
- □ Sexually transmitted diseases
- □ Genetic
- □ Mental Health
- □ Other _____

Note: This authorization is for treatment, payment, or healthcare operations purposes unless otherwise described in the space provided below. While every attempt will be made to protect the privacy of your health information, please note that release of your health information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) or other federal or state laws. This authorization will expire within 365 days unless you specify otherwise. You have the right to revoke this authorization in writing except to the extent that we have released information prior to a revocation. To revoke authorization send written request to: Radiotherapy Clinics of Georgia, Director of Health Information Management, 2349 Lawrenceville Highway, Decatur, GA 30033-3143. You have the right to request your records be provided in electronic format if available. I understand that my health information is protected by federal and state privacy laws and cannot be disclosed without my written consent except as specifically provided by law.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here below.

_____

_____

_____ _____ _____/_____/_____
Signature of Patient or Representative* Relationship to Patient* Date

_____ _____/_____/_____
Signature of Parent/Guardian (minors age 0-17) Date

*** Supporting documentation must be provided**

Attention Staff: This form may only be completed when there is a need to request medical records/films and must be completed in full for each entity from which you are releasing records or to which you are sending records. Under HIPAA, this form is not necessary in order to share or obtain medical information for treatment or payment purposes of the current medical illness. This form is only valid if completely filled out.