ALLIANCE CANCER CARE
RADIATION ONCOLOGY

AUTHORIZATION FOR USE, DISCLOSURE, AND REQUESTING OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ Date of Birth: _____

Address: _____ City, State: _____

I hereby authorize ALLIANCE CANCER CARE to use, disclose, and request my protected health information as indicated below:

_____

_____

PURPOSE OF DISCLOSURE:

- ○ Care and Treatment
- ○ Changing Physicians
- ○ At Patient's Request
- ○ Second Opinion
- ○ Other: _____

INFORMATION TO BE RELEASED:

From Date: _____ To: _____

- ○ Physical Exam Notes
- ○ Lab Reports
- ○ Radiology Reports
- ○ Other: _____

INFORMATION TO BE REQUESTED:

From Date: _____ To: _____

- ○ Physical Exam Notes
- ○ Lab Reports
- ○ Radiology Reports
- ○ Other: _____

I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.

I understand that I may revoke this authorization at any time by notifying Alliance Cancer Care's Privacy Officer at One Hospital Drive, Suite 100 Huntsville, AL 35801, in writing, and this authorization will cease to be effective on the date notified except to the extent the action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other state of federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

My health care and payment for health care will not be affected if I do not sign this form.

I understand that I may request a copy of this form after I sign it.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

_____ _____ or _____ _____

Patient Signature Date Signature of Authorized Person Date

_____

Relationship to Patient

FOR OFFICE USE ONLY

Date Request Filled: _____ By: _____