AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be read, dated, and signed by the patient or by a person authorized by law to give authorization on behalf of the patient.

I,_____, born _____,
(Patient's legal name – First, Middle Initial, and Last) (Patient's D.O.B. Month/Day/Year)

hereby authorize to:

OBTAIN Health Information **FROM**:

_____
(Name of sending person /entity)

_____
(Clinic / Hospital Name)

_____
(Street / Box)

_____
(City / State / Zip)

_____/_____
(FAX #) (PHONE #)

SEND Health Information **TO**:

_____
(Name of receiving person / entity)

_____
(Clinic / Hospital Name)

_____
(Street / Box)

_____
(City / State / Zip)

_____/_____
(FAX #) (PHONE #)

By **initialing** the spaces below, I specifically authorize the release of the following health information:

_____ Office chart notes incl. History & Physicals
_____ Laboratory reports
_____ Pathology reports
_____ Medication list
_____ Radiation Notes
_____ Operative/Procedure reports
_____ Diagnostic imaging reports
_____ Diagnostic Imaging Films

_____ Other _____

I understand that federal or state laws may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information. **By initialing the spaces below, I specifically authorize the release of the following health information:**

_____ **HIV/AIDS** related records including HIV testing
_____ **MENTAL HEALTH** information
_____ **DRUG/ALCOHOL** diagnosis, treatment or referral information
_____ **GENETIC TESTING** information (which may include testing to determine the characteristics of tumor)

I understand that my health information may be re-disclosed by the person or entity receiving my health information from Compass Oncology and that it may no longer be protected under federal or state laws.

I understand that the health information will be used for_____
(List stated purpose – **be specific**)

I voluntarily sign this authorization and I understand that my ability to obtain health care from Compass Oncology will not be affected if I refuse to sign this authorization.

This authorization expires in 180 days, Please specify a date if sooner: _____
We are unable to extend an authorization longer than 6 months. (exp date)

I understand that I may revoke this authorization at any time by notifying Compass Oncology in writing, and that my revocation is not effective to the extent that Compass Oncology has acted in reliance on this authorization. This authorization will expire 180 days from the date of signing or on the expiration date or event specified, if earlier.

_____ _____
Signature of Patient or Person Authorized by Law to Act on Patient's behalf Today's Date

If this authorization is signed by a person authorized by law to act on behalf of a patient, please describe your relationship to the patient:_____