Authorization to use or disclose protected health information

CANCER SPECIALISTS OF TIDEWATER, LTD.
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Fax: (757)436-2912 PH 436-2995 Fax: (757)363-2246 PH 363-8212

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name | Date of Birth | Social Security No.

Address (street, city, state, zip code) | Telephone Number

The following individual or organization is authorized to make the disclosure:
_____ Cancer Specialists of Tidewater, Ltd.
_____ Other (Please Specify) ____
____

This information may be disclosed to and used by the following individual or organization:
_____Cancer Specialists of Tidewater, Ltd.
_____other (please specify)____

Treatment Dates: Purpose of Request:

The following information is to be disclosed: (Please Check)
_____ . . . . . physician notes
_____ . . . . . lab results
_____ . . . . . x-ray reports
_____ . . . . . MRI & CT Reports
_____ . . . . . complete record
_____ . . . . . other ____

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

Other Rights:

a.) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
b.) I understand that I may inspect or obtain a copy of this information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

Signature of patient or legal representative | relationship | Date

Witness:_________________________________Date:_________________________________