# 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 Code: __________________________________________________________________

Contact Person: _________________________ Phone: __________________________ Fax: ___________________

**Method of disclosure**: ☐ Mail ☐ Pick up ☐ Portal ☐ Fax ☐ Email: _______________________________________

**Purpose of the disclosure**: ☐ Continuity of Care ☐ Insurance ☐ Personal ☐ Legal ☐ Other ___________________

**Dates of Treatment**: From: ____________________________________ To: ___________________________________

**Specific reports to be disclosed:**

☐ History & Physical
☐ Laboratory Reports
☐ Operative/Surgical Reports
☐ Progress Notes/Follow-up Notes
☐ Radiology Reports
☐ Consultation Reports
☐ Discharge Summary
☐ Pathology Reports
☐ Records from other facilities
☐ 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
☐ Documentation of AIDS diagnosis
☐ Drug and alcohol abuse treatment records
☐ 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.

Unless revoked earlier, this authorization expires in one year unless 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