PATIENT AUTHORIZATION FOR USE / DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Other name(s) used: _____

Mailing Address: _____

Phone Number: _____ MRN: _____

I authorize: _____ **to release my records to:** **Austin Cancer Center HIM Dept (medical records)**

Address: 9715 Burnet Rd. Building 7, Suite 200 Austin, TX 78758

Contact Person: _____ Phone: (512) _____ Fax: (512) 334-2702

Upcoming appointment / Records are needed before this date: _____

Method of disclosure: ☐ Mail ☐ Fax ☐ Email: ACCHIMDept@austincancercenters.com

Purpose of the disclosure: Continuity of Care / send to my other healthcare provider

Dates of records to be released: ☐ All **Or** From: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY)

Types of records to be released to Austin Cancer Center: Check off the type(s) of materials to be released.

☐ History & Physical	☐ Laboratory Reports	☐ Hospital records (explain below)
☐ Progress Notes/Follow-up Notes	☐ Radiology Reports	☐ Consultation Reports
☐ Operative/Procedure notes	☐ Pathology Reports	☐ Records from other facilities (explain below)
☐ **Images on disc**	☐ All records/entire chart	

☐ Other/Explain: _____

Specific authorization for sensitive information

Do	Do not release	Initials	Do	Do not release	Initials
☐	☐ Mental health information	_____	☐	☐ Genetic information	_____
☐	☐ Drug, Alcohol, or substance abuse	_____	☐	☐ HIV/AIDS test results/treatment	_____

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 Centers in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization might be re-released by the person or organization that receives it and it may then no longer be protected by Federal or Texas privacy regulations.

This authorization expires in one year or on this specific date or event: _____. 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

If this form is signed by a person other than the patient, supporting documentation must be submitted along with this form. Examples include Medical Power of Attorney or documentation of legal guardianship.