****

 **Metro Chicago Surgical Oncology L.L.C.**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Specified Medical information is being requested for:

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**\_\_\_\_\_ **Zip**\_\_\_

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check(s) below indicate(s) that I permit information of this type, if it exists, to be released. I understand that if I do circle the affliction, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_will release such information about me if it exists.

HIV/AIDS Sexually transmitted diseases Mental Health

Treatment for alcohol and/or drugs Genetic

 **For Office Use Only**

Release the information from: Disclose the Information To:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested Medical Information authorized to be released: (Please circle items)

Consult PSA Scores All Ct Scans

OP Report/ Procedure Report Tumor Markers Mammograms

Follow Up notes Pathology Reports Radiotherapy Records

Progress Notes Pathology Slides Chemotherapy Flow Sheet

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: This authorization is for treatment, payment, or healthcare operations purposes unless otherwise described in the space provided below. While every attempt will be made to protect the privacy of your health information, please note that release of your health information to an authorized person or organization could be subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act (HIPPA) or federal or state laws. This authorization will expire within 365 days unless you specify otherwise. You have the right to revoke this authorization in writing except to the extent that we have released information prior to the revocation. To revoke authorization, send your written request to: Director if Health Information Management, 53 Perimeter Center, Suite 500, Atlanta GA 30346. You have the right to request your records be provided in electronic format if available.

I understand that my health information is protected by federal land state privacy laws and cannot be disclosed without my written consent except as specifically provided by law.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits unless otherwise described in the space provided below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or representative Relationship to Patient Date**