Carolina Oncology Specialists

A Partner of OneOncology

AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____ /_____ /_____

PHONE: _____

PURPOSES OF DISCLOSURE:

☐ Legal ☐ Personal Use ☐ Physician Request

☐ Changing Physicians ☐ Insurance ☐ Other_____

SPECIFIC INFORMATION TO BE RELEASED (Example: Office Visit Notes, Laboratory Reports, etc.)

FROM:

_____

_____

_____

_____

_____

_____

TO:

Carolina Oncology Specialists, PA

2711 Randolph Road, Suite 400

Charlotte, NC 28207

General Phone: 704-342-1900

Fax: 704-377-0353

Note: As to what may be released, it will be at the medical office's discretion. The amount reasonably necessary for certain identified purposes, pending purpose of disclosure.

DATES OF SERVICE RANGE: **FROM**_____ /_____ /_____ **TO**_____ /_____ /_____

Note: By signing this authorization, you acknowledge that it extends to all or any part of the records designated above, which may include final findings, diagnosis, treatment, assessment, dates of service, psychiatric information, HIV test results, alcohol/drug abuse, etc., unless specifically excluded by you. I understand that this authorization will expire 90 days from the date of signature.

_____ _____

Signature of Patient Date

_____ _____ _____

Parent/ Legal Guardian/ Authorized Person Date Relationship to patient

NOTICE TO PATIENTS: The patients or the patient's representative may inspect and/or copy the health information to be used or disclosed in accordance with practice policies. You may refuse to sign this authorization or revoke it in writing at a later date if the information has not already been disclosed.

Return completed and signed form by fax 704-377-0353; or mailing to the address listed; or in person during office business hours.

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____ /_____ /_____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE: _____

CAROLINA ONCOLOGY SPECIALISTS, PA MAY RELEASE THE FOLLOWING INFORMATION:

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes

☐ Other_____ ☐ Diagnosis/Studies ☐ Office Visit Notes

ENTITY OR PERSON WHO WILL RECEIVE THE INFORMATION:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____ PHONE: _____

☐ Send the information electronically. Email address: _____

☐ Send the information via Fax. Fax# _____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed in the document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____

Print Mane of signature above: _____

DATE: _____

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on

HOW REVOKED: ☐ Orally (if person or via phone) ☐ In writing (place copy in patient's file)