Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Patient Phone Number: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I authorize the use or disclosure of the above named individual's health information

2. The following individual or organization is authorized to make the disclosure:

   Name: _____

   Address: _____

3. The type and amount of information to be used or disclosed is as follows:

   _____ Physician Dictation
   _____ Laboratory Results
   _____ Dosimetry Records
   _____ Consultation Reports
   _____ Radiology Reports
   _____ Surgery/Pathology
   _____ Diagnostic Films
   _____ Portal Films/Simulation Films
   _____ Other: _____

   The time frame for the disclosure information is: from (date) _____ through (date)_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

   Name: _____

   Address: _____

   _____

   Purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIM Director.

_____	_____	_____
Date	Patient Signature or Legal Representative	Witness

If signed by legal representative, state the relationship to the patient: _____