Lone Star Oncology

A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

REQUEST FOR RELEASE OF RECORDS

Patient Name _____ Date of Birth _____

Address _____ City _____ State/Zip _____

I, _____, request a copy of my medical record (listed below) from the office of:

_____

_____

Name and address of practitioner

To be sent to Lone Star Oncology, 3201 S. Austin Ave., Suite 315, Georgetown, TX 78626
Phone: (512) 358-9428

- New patient MD visit note
- Most recent MD follow up visit note
- Most recent lab results and most recent tumor markers
- All pathology
- All PET/CT scans, CT scans, and radiology
- All genetic results
- Clinical Summary page
- Treatment flowsheet
- 3 months of Chemotherapy calendars

_____ I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. Disclosure by the recipient will no longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original. If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/ she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may only be signed by the next-of-kin or personal representative of the estate.

I understand that the provision of treatment or payment cannot be conditioned on my signing of this authorization unless otherwise permitted under state and federal law. However, if treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I understand that this release is revocable by me at any time, except to the extent that action has already been taken in reliance to it. The request will become effective upon delivery of the written revocation to the disclosing entity. Unless revoked, this authorization for release of information expires in one year after the date of signature.

_____ _____

Patient Name (Print) Date

_____

Patient Date of Birth

_____ _____

Patient or Guarantor (Signature) Date