



A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

Authorization For Release of Patient-Identifiable Health Information

(If under 18 years of age, parent or guardian must sign)

PATIENT IDENTIFICATION: Patient ID#: Date of Service: Name: Address: Previous Name: New Address: Date of Birth: City: State/Zip: Social Security #: City: State/Zip:

I request and authorize the use or disclosure of the above named individual's health information as described below. Cancer & Blood Specialists of NOVA is authorized to make this disclosure.

For the purpose of:

Continuation of medical treatment, Personal use, Administrative (i.e., FMLA), Payment of bill, Legal or insurance purposes, Patient Request, Worker's Comp/Insurance/Claim, Other (specify)

The type and amount of information to be disclosed is as follows:

Table with columns for Dates (from/to) and checkboxes for General - Documents, Laboratory Reports, Physician Summary, Treatment Plan, Orders, Visit Notes, Radiology Reports, Images, Nurses Notes (MAR), Entire Record, Billing, Other (specify)

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

(initial) This information may be disclosed to and used by the following individual or organization:

RELEASE RECORDS TO (Where records should be sent):

Same as above OR: Name/Agency/Healthcare:

Address City State Zip

\*Email: Fax:

\*Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method you understand and accept the inherent risks of receiving your records via email to the address you specify.

INFORMATION REQUESTED: Fees may apply.

(initial) 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.

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.

Signature of Patient/Legal Representative Date

Relationship to Patient:

Release - EFFECTIVE 9-07 Revised: 08-16-2012; 10 09 2014; 06 26 2017; 12 01 2020; 09 01 2021

I AM ENTITLED TO A COPY OF THIS AUTHORIZATION