AUTHORIZATION TO DISCLOSE AND/OR RELEASE MEDICAL INFORMATION

Patient Name **Date of Birth**

Please **REQUEST** Medical Information **FROM**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Please **SEND** Medical Information **TO**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The health information will be released and/or disclosed for the following purpose(s):

☐ Treatment/Continuing Medical Care (e.g. Other Healthcare Providers, Hospital, Physicians)	☐ Legal purposes (e.g. Attorneys)	☐ Personal Use
☐ Billing or Claims	☐ Insurance (e.g. life insurance application)	☐ Disability Determination
☐ School	☐ Employment	
☐ Other, please specify:		

Check the box which type of information is to be released and/or disclosed:

☐ General Medical Information (from _____ to _____)
☐ Information regarding Specific Treatment (from _____ to _____)
☐ Lab Results (from _____ to _____)
☐ Other, please specify: _____
☐ Entire medical record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).

This authorization expires on/upon _____
(insert date or event that triggers expiration)

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.

I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

_____ _____
Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____
Name of Personal Representative Relationship to Patient

SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood