

**Authorization For Release of Patient-Identifiable Health Information**  
(If under 18 years of age, parent or guardian must sign)

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

I request and authorize the use or disclosure of the above named individual's health information as described below. **Heartland Oncology & Hematology** is authorized to make this disclosure.

**For the purpose of:**

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

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

Dates (from/to)		Dates (from/to)	
<input type="checkbox"/> General - Documents		<input type="checkbox"/> Radiology Reports	
<input type="checkbox"/> Laboratory Reports		<input type="checkbox"/> Images, specify exam(s)/body part(s)	
<input type="checkbox"/> Physician Summary		<input type="checkbox"/> Nurses Notes (MAR)	
<input type="checkbox"/> Treatment Plan		<input type="checkbox"/> Entire Record	
<input type="checkbox"/> Orders		<input type="checkbox"/> Billing	
<input type="checkbox"/> Visit Notes		<input type="checkbox"/> Other (specify)	

I understand that information may be released including the following categories unless I specifically deny the release. **(Initial any category NOT to be released.)**

Substance Abuse\* \_\_\_\_\_ Mental Health \_\_\_\_\_ HIV/AIDS-related information \_\_\_\_\_ Genetic Tests/ Information \_\_\_\_\_

\*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). Therefore prohibiting you from making any further disclosure unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**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. 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 6 months 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

**I AM ENTITLED TO A COPY OF THIS AUTHORIZATION**