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 Phone (850) 914-0700 • Fax (850) 914-0777  
 2614 Jenks Avenue • Panama City, FL 32405  
 Phone (850) 769-2996 • Fax (850) 769-4665

# FLORIDA CANCER AFFILIATES

2417 Jenks Avenue • Panama City, FL 32405  
 Phone (850) 215-5300 • Fax (850) 215-5398  
 2100 State Street • Panama City, FL 32405  
 Phone (850) 763-0036 • Fax (850) 763-0259

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

### 1. Patient Information

Name - Last, First, MI			
Street Address			
City	State	Zip Code	
Account #	Birthdate	Phone No.	

### 2. Information to be Disclosed. (Please check only one box)

- Comprehensive overview of entire chart (contains all Visit Notes, BM/BX Notes, Pathology, Treatment Notes, x-ray, EKG and lab reports)
- Records pertaining to: \_\_\_\_\_ (Specific Medical Information, reports, etc. and/or dates of svc)
- AIDS or AIDS related illness, and/or HIV test results  Alcohol and/or Drug Abuse Treatment
- Psychiatric consults and mental illness, developmental abilities  Sexually Transmitted Disease
- Other (describe): \_\_\_\_\_

### 3. Disclosed By:

Name		
Address		
City	State	Zip Code

### 4. Disclosed To:

Name	<b>Florida Cancer Affiliates</b>	
Address	<b>Syed Mahmood, M.D.   S. Tariq Mahmood, M.D.</b>	
City	<b>2614 Jenks Avenue</b>	Zip Code
	<b>Panama City, FL 32405</b>	

### 5. Purpose or need for disclosure. (Please check all applicable categories)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> further medical care      | <input type="checkbox"/> payment of insurance claim | <input type="checkbox"/> legal investigation |
| <input type="checkbox"/> application for insurance | <input type="checkbox"/> vocational rehabilitation  | <input type="checkbox"/> patient use         |
| <input type="checkbox"/> disability determination  | <input type="checkbox"/> other _____                |  |

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization will be effective for an additional time period. (To specify an additional time period, please check the box below. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)

Other specific expiration date: \_\_\_\_\_ (mm/dd/yy) \_\_\_\_\_

7. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Florida Cancer Affiliates will not be affected if I refuse to sign this authorization.

8. I understand that I may revoke this authorization at any time by notifying Florida Cancer Affiliates in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization.

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

In accordance with the conditions listed above. I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

If signed by person other than patient, state relationship and authority to do so.

Relationship: \_\_\_\_\_

Patient is:  Minor  Incompetent/Incapacitated  Deceased

Legal Authority:  Legal Guardian  Parent of Minor  Spouse of Deceased

Health Care Agent \_\_\_\_\_

Personal Representative of Deceased  Other \_\_\_\_\_

<b>To be completed by Ocala Oncology Personnel:</b>	
Completed by _____	Initials _____
Date _____	

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Distribution: Original - Medical Record Copy to: Patient or Representative