FLORIDA CANCER AFFILIATES

☐ 3611 Little Road • Trinity, FL 34655
Phone (727) 372-9159 • Fax (727) 376-8703

☐ 14535 Cortez Blvd. • Brooksville, FL 34613
Phone (352)596-3622 • Fax (352) 596-0901

☐ 13904 Lakeshore Blvd., Ste. 410 • Hudson, FL 34667
Phone (727) 862-5489 • Fax (727) 862-0397

☐ 11373 Cortez Blvd., Ste. 200 • Brooksville, FL 34613
Phone (352) 597-4998 • Fax (352) 596-6051

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		
Address		
City	State	Zip Code

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

☐ further medical care
☐ application for insurance
☐ disability determination
☐ payment of insurance claim
☐ vocational rehabilitation
☐ other _____
☐ legal investigation
☐ patient use

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 _____

To be completed by Ocala Oncology Personnel:

Completed by _____
Initials

Date _____