

- 301 W. 26th Street • Lynn Haven, FL 32444  
Phone (850) 914-0700 • Fax (850) 914-0777
- 2614 Jenks Avenue • Panama City, FL 32405  
Phone (850) 769-2996 • Fax (850) 769-4665
- 2417 Jenks Avenue • Panama City, FL 32405  
Phone (850) 215-5300 • Fax (850) 215-5398

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

We may release your health information, including information about your condition, to a family member or friend who may be involved in your medical care or who helps pay for your care. As described in our Notice of Privacy Practices, you have the right to request that we do not release your health information to certain individuals.

Please use the form below to indicate with whom we may release your health information to notify or assist in the notification of a family member or friend who may be involved in your care.

**Release of Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

- Spouse \_\_\_\_\_
- Child(ren) \_\_\_\_\_
- Other \_\_\_\_\_
- Information is not to be released to anyone.

This HIPAA Release will remain in effect until terminated by me in writing.

**When leaving a messages:**

Please call  my home  my work  my cell    Number: \_\_\_\_\_

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- \_\_\_\_\_

The best time to reach me is (day of week) \_\_\_\_\_

between (time) \_\_\_\_\_ and \_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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  payment of insurance claim  legal investigation
- application for insurance  vocational rehabilitation  patient use
- disability determination  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