INFORMATIONAL GUIDE *for Completing the Authorization for Release of Protected Health Information Form*

Patient Information:
- Full Name at Time of Visit
- Birth Date AND, either
- Social Security Number, OR
- Medical Record Number

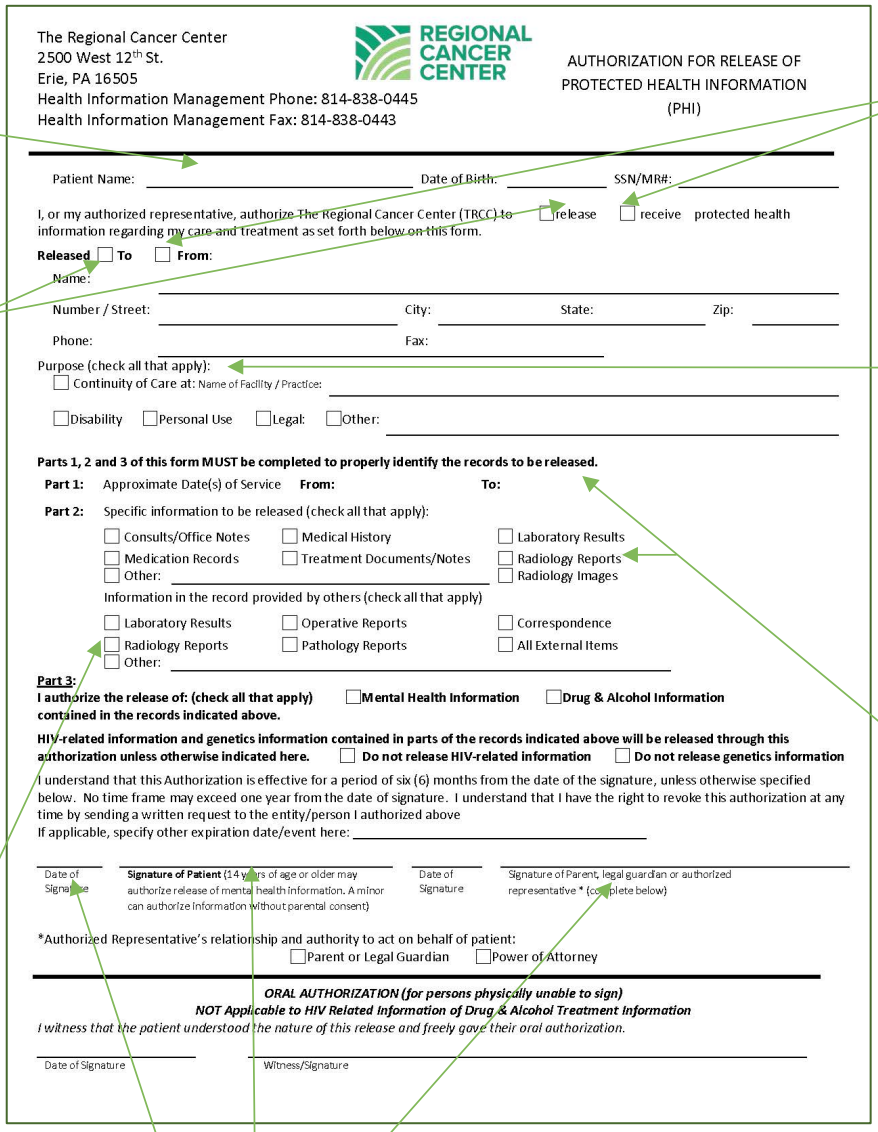
Receive From/ Released From:

Physician Office/ Medical Facility:
- Facility Name
- Address
- Phone and Fax Number

Released To Recipient Information for Physician Office/ Medical Facility:
- Facility Name
- Address
- Phone and Fax Number

Released To Recipient Information for Personal Use
- Name (of person picking up/receiving the documents)
- Address (where the documents will be sent)
- Phone Number (of person picking up/ receiving the documents)

Purpose: Indicate the purpose for the release:
- Continuity of Care – treatment, appointment or procedure with another provider/ facility
- Disability – for the use of filing a disability claim
- Personal Use
- Legal – for the use in legal matters
- Other – please explain



The Regional Cancer Center
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Health Information Management Phone: 814-838-0445
Health Information Management Fax: 814-838-0443

REGIONAL CANCER CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____ SSN/MR#: _____

I, or my authorized representative, authorize The Regional Cancer Center (TRCC) to ☐ release ☐ receive protected health information regarding my care and treatment as set forth below on this form.

Released ☐ **To** ☐ **From**:

Name: _____

Number / Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose (check all that apply):

☐ Continuity of Care at: Name of Facility / Practice: _____

☐ Disability ☐ Personal Use ☐ Legal: ☐ Other: _____

Parts 1, 2 and 3 of this form MUST be completed to properly identify the records to be released.

Part 1: Approximate Date(s) of Service **From:** **To:**

Part 2: Specific information to be released (check all that apply):

☐ Consults/Office Notes ☐ Medical History ☐ Laboratory Results
☐ Medication Records ☐ Treatment Documents/Notes ☐ Radiology Reports
☐ Other: _____ ☐ Radiology Images

Information in the record provided by others (check all that apply)

☐ Laboratory Results ☐ Operative Reports ☐ Correspondence
☐ Radiology Reports ☐ Pathology Reports ☐ All External Items
☐ Other: _____

Part 3:
I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug & Alcohol Information contained in the records indicated above.**

HIV-related information and genetics information contained in parts of the records indicated above will be released through this authorization unless otherwise indicated here. ☐ **Do not release HIV-related information** ☐ **Do not release genetics information**

I understand that this Authorization is effective for a period of six (6) months from the date of the signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above
If applicable, specify other expiration date/event here: _____

Date of Signature | **Signature of Patient** (14 years of age or older may authorize release of mental health information. A minor can authorize information without parental consent) | Date of Signature | Signature of Parent, legal guardian or authorized representative * (complete below)

*Authorized Representative's relationship and authority to act on behalf of patient:
☐ Parent or Legal Guardian ☐ Power of Attorney

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information of Drug & Alcohol Treatment Information
I witness that the patient understood the nature of this release and freely gave their oral authorization.

Date of Signature | Witness/Signature

Dates of Service and Service Type:

Select type(s) of records to be released and dates of service, or a date range of records to be released*:

**If patient dates of service are unknown, approximate by month and/or year.*

Other Documents to be Released: Check specific name of report(s)/ records to be released that correspond with the dates of service provided to RCC by other providers.

Date, Signature and Additional Documentation:
The patient or the patient representative must sign and date the authorization.

If signed by a patient representative, a description of the authority to act for the individual is required.

The authorized representative should detail the relationship and authority on the line provided.

For Assistance in Completing the Form or to Check on the Status of Your Request:

Please contact RCC's Medical Records Staff at 814.838.0445.