KATMAI
ONCOLOGY GROUP
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Authorization to Disclose Protected Health Information

Patient Name:_______________________________ Date of Birth:________________ Day Phone:______________
Address:___________________________________ City/State/Zip:____

Medical records to be released FROM:	**Medical records to be released TO:**
Name of Facility:	*Name of Facility / Person:*
Address:	*Address:*
Phone Number:	*Phone Number:*
Fax Number:	*Fax Number:*

Medical records to be released:

- ☐ Entire Chart

OR specific information:

- ☐ Physician Office Notes
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Operative/Procedure Reports
- ☐ Other:___________________________

- ☐ Date Range:____________to_____________

OR

- ☐ All dates of service

For the purpose of:

- ☐ *Continuation of Care*
- ☐ *Payment / Billing*
- ☐ *Legal Request*
- ☐ *Personal Records*
- ☐ *Other:________________________*

If you would like any of the following sensitive information to be disclosed, please initial below

_____*Drug / Alcohol Abuse* _____*Mental Health (not including psychotherapy notes)* _____*HIV / STD information*

Authorization – I understand that:

- Authorizing the disclosure of this is voluntary. My right to treatment, payment, enrollment or eligibility for benefits is not contingent on signing this form.
- I may revoke this authorization in writing submitted at any time to the Medical Records Department. No additional information will be released after the date this authorization has been revoked.
- If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy.
- If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years. *(Specify new expiration date:__________)*
- I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule, and the Privacy Act of 1974.

____ ____________________

Signature of Patient or Personal Representative *(indicate relationship to patient)* Date of Signature