Community CancerCare
Radiation Oncology

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*Patient Name: _____ Medical Record #: _____

*Date of Birth: _____ / _____ / _____ *Date of Request: _____/_____/_____

All fields marked with an asterik (*) must be completed to ensure all required information is submitted with request.

I authorize the following organization to release information as stated below from the patient health information record:

Information to be Released *FROM* :	**Information to be Released *TO* :**
Organization: **Community Cancer Care**	*Name (Organization, Provider or Patient):
Address: **100 Haynes Street, Manchester, CT 06040**	*Address:
Phone: **860-533-4000** Fax: **860-533-4011**	*Phone: Fax:

Information to be Released:

***Dates of service for records requested: Beginning _____ Thru _____**

❑ Treatment Notes ❑ Lab/Pathology Reports ❑ Clinic Notes

❑ Other (please specify) _____

Purpose of Release:

***Please select purpose for requested record release:**

❑ Continuing care ❑ Copies for own use ❑ Transfer to another provider ❑ Legal ❑ Coordination with School

□ Other (please specify) _____

Method of Release:

***How would you like your records to be released? Choose one below:**

❑ Fax to number listed above ❑ Mail to address listed above

❑ E-mail to: _____

Authorization for General Release of Information

I understand that:

• Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.

• I can cancel this authorization at any time by contacting Community Cancer Care.

• understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

• Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

•Community Cancer Care will complete all record release requests within 30 days of receiving the signed release.

This authorization will expire 90-days from the date signed below unless another date or event is entered below:

_____

(Note: If the disclosure is to an employer or financial institution, this authorization will expire 90 days from the date signed by you.)

Signature of Patient or Legal Representative:

By signing below, I authorize the release of my protected health information according to the terms identified above on this release form.

_____ _____

***Signature of Patient/Legal Guardian** ***Date**

For Internal Office Use Only:

Date Completed: _____ **Completed by:** _____

☐ Faxed ☐ Mailed ☐ E-Mailed ☐ Patient picked up in-person