# AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

**This authorization must be read, dated and signed by the patient or by a person authorized by law to give authorization on behalf of the patient.**

I, _____, born _____,
(Patient's legal name - First, Middle Initial, and Last) (Patient's D.O.B. Month/ Day/Year)

hereby authorize Compass Oncology to:

**OBTAIN** Health Information **FROM**:

_____
(Name of sending person/entity)

_____
(Clinic / Hospital Name)

_____
(Street / Box)

_____
(City / State / Zip**)**

_____/_____
(FAX #) (PHONE #)

**SEND** Health Information **TO:**

_____
(Name of sending person/entity)

_____
(Clinic / Hospital Name)

_____
(Street / Box)

_____
(City / State / Zip)

_____/_____
(FAX #) (PHONE #)

**By initialing the spaces below, I specifically authorize the release of the following health information:**

____ Office chart notes incl. History & Physicals.
____ Laboratory reports
____ Pathology reports
____ Medication Flow sheets inc. known Allergies.
____ Radiation Therapy Logs, notes or records.
____ Consultation Notes.
____ Diagnostic imaging reports and Films
____ Billing and accounting statements.

____ Other_____

I understand that federal or state laws may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information. **By initialing the spaces below, I specifically authorize the release of the following health information:**

____ **HIV/AIDS related records including HIV testing** ____ **MENTAL HEALTH information**

____ **DRUG/ALCOHOL diagnosis, treatment or referral information**

____ **GENETIC TESTING information (which may include testing to determine the characteristics of tumor)**

**I understand that my health information may be re-disclosed by the person or entity receiving my health information from Compass Oncology and that it may no longer be protected under federal or state laws.**

I understand that the health information will be used for_____.
(List stated purpose - **be specific**)

I voluntarily sign this authorization and I understand that my ability to obtain health care from Compass Oncology will not be affected if I refuse to sign this authorization.

This authorization expires on: _____ _____
(Please specify the date or an event that triggers the expiration) (event) (exp date)

**I understand that I may revoke this authorization at any time by notifying Compass Oncology in writing, and that my revocation is not effective to the extent that NCS has acted in reliance on this authorization. This authorization will expire 180 days from the date of signing or on the expiration date or event specified, if earlier.**

_____ _____
Signature of Patient or Person Authorized by Law to Act on Patient's behalf Today's Date

If this authorization is signed by a person authorized by law to act on behalf of a patient, please describe your relationship to the

patient: _____