HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA, PC

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MEDICAL RECORD RELEASE AND GENERAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(PLEASE READ ENTIRE DOCUMENT BEFORE SIGNING)

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record as set forth below.

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY (Recipient)
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
TELEPHONE FAX	TELEPHONE FAX

III. The purpose or need for this disclosure is:

☐ Medical Care ☐ Legal Issues ☐ School/Work ☐ Research

☐ Personal Use ☐ Insurance ☐ Disability Claim ☐ Other (specify)_____

IV. The information to be disclosed from my health record: ***check appropriate box(es)***

☐ Entire Record
☐ Only information related to (specify condition) _____
☐ Only the period from _____to_____
☐ Other (specify) _____

In addition, I also authorize the use /disclosure of the following information, which requires specific authorization:
Please check and initial applicable box(es):

☐ Initials ____ Alcohol/ Substance Abuse Treatment ☐ Initials ____ HIV/ AIDS-related treatment
☐ Initials ____ Sexually Transmitted Diseases ☐ Initials ____ Mental Health (Other than Psychotherapy Notes)
☐ Initials ____ Psychotherapy Notes (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that the terms of this Release and Authorization are governed by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as may be amended from time to time. I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and therefore will no longer be protected by HIPAA after disclosure. I understand that I may revoke this authorization by submitting a written request to the Privacy Officer of the disclosing entity, but only to the extent that action has not already been taken in reliance on this authorization. This authorization will terminate *one year* from the date of my signature *unless* a different expiration date or expiration event is stated (specify date, if applicable)_____

I understand that the above disclosing entity will not condition treatment, enrollment, payment or eligibility for care on my providing this authorization.

This information is to be released for the purpose stated above and may not be used by the Recipient for any other purpose.

PATIENT IDENTIFICATION (PLEASE PRINT)

NAME (Last, First, M)		
ADDRESS		
CITY/STATE/ZIP	DATE OF BIRTH	MR#
SIGNTURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)		Date