

Willamette Valley Cancer Institute and Research Center (WVCI)

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AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Patient Name

Date of Birth

Please **REQUEST** Medical Information **FROM:**

Please **SEND** Medical Information **TO:**

Person/Organization Name

Person/Organization Name

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone Number

Fax Number

Phone Number

Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The information will be released, at the request of the patient, for the following purpose:

By ***initialing*** the spaces below, I authorize the release of the specified medical records. This may include information contained in my medical record that was provided to WVCI from another health care provider or facility. Further, by signing this Authorization form, it is understood that WVCI may continue to release information or copies of medical records to the above named party, as may be requested, through the expiration date noted below.

_____ Office Chart Notes	_____ Hospital Reports & Discharge Summaries	
_____ Pathology Reports	_____ Laboratory Reports	
_____ Radiation Therapy Reports	_____ X-Ray Reports	_____ Psychotherapy Notes
_____ Consultation and H&P Reports	_____ Medication Flow Sheet	_____ HIV Test Results
_____ Billing / Account Summary	_____ Social Work Information	
_____ Entire Medical Record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).		
_____ Attending Physician Statement/FMLA		
_____ Other, Please Specify _____		

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws. I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. **This Authorization will expire one hundred eighty (180) days from the date of signing or notification that disability benefits have ended.**

Signature of Patient

Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

Name of Personal Representative

Relationship to Patient