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PATIENT DISCLOSURE TO RELEASE OUR RECORDS

PATIENT NAME: _____ DATE: _____

DOB: _____ SOCIAL SECURITY # _____ — _____ — _____

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME ____ YES ____ NO

I AUTHORIZE MID FLORIDA HEMATOLOGY AND ONCOLOGY CENTERS, PA/MID FLORIDA CANCER CENTERS TO RELEASE MY RECORDS IN THEIR ENTIRETY TO:

PLEASE FAX RECORDS TO _____

Purpose of Disclosure:

_____ Continuing care with another physician or hospital _____ Personal copy

_____ Other: _____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____