Willamette Valley Cancer Institute and Research Center (WVCI)

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this information*.

I, ____ ______________________ ____________________

Patient Legal Name - First, Middle Initial, Last Alternative Names Used Date of Birth

hereby authorize Willamette Valley Cancer Institute and Research Center to release and/or disclose the health information as indicated below to the health care provider, entity, or person I have indicated below.

1. At the request of the patient, health information will be released for the following purpose:

- ☐ Treatment / Continuing Medical Care (e.g. Physicians, Hospital)
- ☐ Disability / FMLA
- ☐ Billing or Claims
- ☐ Insurance (e.g. Life insurance application)
- ☐ Legal Purposes (e.g. Attorneys)
- ☐ Personal Use
- ☐ Other ________________

2. I authorize Medical Information to be:

a) Requested From ____

Individual or Facility

____

Mailing Address

____

City/State, Zip

____

Phone Fax

b) Sent To ____

Individual or Facility

____

Mailing Address

____

City/State, Zip

____

Phone Fax

3. By *__initialing__* the spaces below, I specifically authorize the release of the following health information.

_____ Entire Medical Record

_____- OR - last 2 years of my entire Medical Record (<u>excluding</u> items in # 4 below)

_____ -OR- for this specific time period:

____

From To

_____ Office Chart Notes

_____ Pathology Reports

_____ Laboratory Reports

_____ Radiation Therapy Reports

_____ Billing / Account Summary

_____ Imaging Reports and / or films

_____ Consultation and H&P Reports

_____ Hospital Reports / Consultations

_____ Attending Physician Statement/FMLA

_____ Other, Please Specify _____________

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

_____ Genetic Testing

_____ HIV/AIDS related records

_____ Mental health Counseling and/or treatment

_____ Drug/Alcohol diagnosis, treatment or referral

5. 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.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.
- I may revoke this authorization at any time by notifying Willamette Valley Cancer Institute and Research Center 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 <u>OR</u> on the expiration date noted below, if earlier.**

____

Please specify the Event or a Date that triggers the expiration Exp Date

6. Signature:

____ ____________________

Signature of Patient Today's 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

For WVCI Use Only

Date Received: ________________________**MRUN #** ________________ **Acct #** ______________________ **☐ Identity and authority verified**

☐ Fees explained if needed **☐ Records sent by** ____ **Date/Time** ________________