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 (excluding 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 OR on event or date noted below.**

_____
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: _____ **Received By:** _____ **MRN #** _____ ☐ **Identity and authority verified**

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