FLORIDA CANCER SPECIALISTS & Research Institute

Authorization For Release of Patient-Identifiable Health Information
(if under 18 years of age, parent or guardian must sign)

Name of Patient:	Patient ID #	Date of Service:
Patient Address:	Date of Birth:	Phone:

I authorize the use or disclosure of the above named individual's health information as described below. **FLORIDA CANCER SPECIALISTS** is authorized to make this disclosure for the purpose of:

□ Continuation of Medical Treatment	□ Payment of Bill	□ Workers' Compensation
□ Personal Use	□ Legal or Insurance Purposes	

The type and amount of information to be disclosed is as follows:

Dates		Dates
□ General - Documents	□ Diagnostic Imaging Reports	
□ Laboratory Reports	□ Nurses Notes (MAR)	
□ Physician Summary	□ Other (specify)	
□ Treatment Plan	□ Entire Record	
□ Orders	□ Visit Notes	

_____(initial) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis. It may also include information about behavior or mental health services, and treatment for alcohol and drug use.

_____(initial) This information may be disclosed to and use by the following individual or organization:

_____
Name of Physician or individual where records are to be sent

_____
Address City State Zip

_____(initial) I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. Disclosure by the recipient will not longer be protected by the federal regulations governing the Privacy of Individually Identifiable Health Information (45 C.F.R. Part 164). A photocopy of this authorization shall have the same effect as the original.

If the patient is a minor, this authorization must be signed by a parent or legal guardian. If the patient is physically unable to sign this authorization, he/she should put an "X" on the signature line and have his/her assent witnessed. If the patient has been declared mentally incompetent, this authorization may be signed by a legally appointed guardian. If the patient is deceased, this authorization may be signed by the next-of-kin or personal representative of the estate.

This authorization for release of information expires in one year after the date of signature.

I understand that this release is revocable by me, in writing, at any time except to the extent this action has been taken in reliance to it.

_____ _____
Signature of Patient Date

_____ _____ _____
Consenting Party Signing in Lieu of Patient Relationship Date