

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

NAME OF PRACTICE : **HEMATOLOGY/ ONCOLOGY CLINIC**

PATIENT'S NAME: _____

PLEASE CHECK ALL ITEMS THAT CAN BE DISCLOSED:

- SCHEDULED APPOINTMENTS
- LAB ORDERS
- LAB RESULTS
- TREATMENT ORDERS FOR OFFICE
- TREATMENT ORDERS FOR HOME
- PRESCRIBED MEDICATIONS
- PERMISSSION TO PICK UP ANY WRITTEN PRESCRIPTIONS
- LIST ANY OTHER INFORMATION TO BE GIVEN TO DESIGNATED PERSONS

THE PURPOSE OF THIS DISCLOSURE RELEASE FORM IS TO PROTECT YOUR PRIVACY.

PLEASE LIST ALL PERSONS TO WHOM THE PRACTICE MAY DISCLOSE INFORMATION. INFORMATION WILL BE ONLY GIVEN TO THOSE LISTED.

YOU HAVE THE RIGHT TO CHANGE THIS AUTHORIZATION AT ANY TIME.
THE AUTHORIZATION IS NOT A CONDITION FOR TREATMENT IN THIS OFFICE.
YOU HAVE A RIGHT TO A COPY OF THIS DOCUMENT.

THIS DOCUMEN EXPIRES DEC. 31, 2020
THE PRACTICE MAKES EVERY EFFORT TO PROTECT THE
PRIVACY OF YOUR MEDICAL INFORMATION.

SIGNATURE _____ DATE _____