

# HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA, PC

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## MEDICAL RECORD RELEASE AND GENERAL AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(PLEASE READ ENTIRE DOCUMENT BEFORE SIGNING)

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record as set forth below.

II. The information is to be disclosed by:		And is to be provided to:	
NAME OF FACILITY		NAME OF PERSON/ORGANIZATION/FACILITY (Recipient)	
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
TELEPHONE	FAX	TELEPHONE	FAX

### III. The purpose or need for this disclosure is:

- Medical Care       Legal Issues       School/Work       Research  
 Personal Use       Insurance       Disability Claim       Other (specify) \_\_\_\_\_

### IV. The information to be disclosed from my health record: *check appropriate box(es)*

- Entire Record  
 Only information related to (specify condition) \_\_\_\_\_  
 Only the period from \_\_\_\_\_ to \_\_\_\_\_  
 Other (specify) \_\_\_\_\_

### In addition, I also authorize the use /disclosure of the following information, which requires specific authorization:

#### *Please check and initial applicable box(es):*

- Initials \_\_\_\_\_ Alcohol/ Substance Abuse Treatment       Initials \_\_\_\_\_ HIV/ AIDS-related treatment  
 Initials \_\_\_\_\_ Sexually Transmitted Diseases       Initials \_\_\_\_\_ Mental Health (Other than Psychotherapy Notes)  
 Initials \_\_\_\_\_ Psychotherapy Notes (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that the terms of this Release and Authorization are governed by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as may be amended from time to time. I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the Recipient listed above and therefore will no longer be protected by HIPAA after disclosure. I understand that I may revoke this authorization by submitting a written request to the Privacy Officer of the disclosing entity, but only to the extent that action has not already been taken in reliance on this authorization. This authorization will terminate one year from the date of my signature *unless* a different expiration date or expiration event is stated (specify date, if applicable) \_\_\_\_\_

I understand that the above disclosing entity will not condition treatment, enrollment, payment or eligibility for care on my providing this authorization.

*This information is to be released for the purpose stated above and may not be used by the Recipient for any other purpose.*

### PATIENT IDENTIFICATION (PLEASE PRINT)

NAME (Last, First, M)			
ADDRESS			
CITY/STATE/ZIP	DATE OF BIRTH	MR#	
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)			Date