CARTI

Authorization to Release Protected Health Information

TO BE SCANNED

Instructions: Complete all sections of this form. This form may be invalid if any section is incomplete.

Medical Record Number	Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*

Release Information From

- ☐ CARTI Imaging Center
- ☐ CARTI Medical Oncology Clinic Location: _____
- ☐ CARTI Radiation Oncology Clinic Location: _____
- ☐ Other *(Specify facility/individual & address below, including phone/fax if known.)*

_____

_____

_____

Release Information To

☐ CARTI ☐ Other

(Specify facility/individual & address below, including phone/fax if known.)

_____

_____

_____

_____

Purpose of Release

☐ Treatment/Continued Care	☐ Personal	☐ Legal Purposes
☐ Application for Insurance	☐ Disability Determination	☐ Payment of Insurance Claim

☐ Other _____

Information to be Released

Service Dates From _____ To _____

Information Needed By (Optional) _____

☐ History and Physical	☐ Med Onc Treatment Records	☐ Laboratory Reports	☐ Rad Onc Treatment Records
☐ Consultations/Evaluations	☐ Pathology Reports	☐ Radiology Reports	☐ Discharge/End of Treatment Summary
☐ Clinic/Progress Notes	☐ Operative Reports	☐ Radiology Images	☐ Billing Information

☐ Other _____

This authorization will expire one year from the date of signing unless otherwise indicate here: _____.

I understand by signing this authorization:

- I authorize the use of disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to the authorization may not further use of disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

ATTENTION: Please read carefully.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (Month DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*	Phone
Mailing Address of Patient - Street	City, State, Zip Code