



Authorization to Release Protected Health Information

TO BE SCANNED

Requests for medical records may take up to five (5) business days to process.

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

Release Information To

Release Information From options: CARTI Imaging Center, CARTI Medical Oncology Clinic Location, CARTI Radiation Oncology Clinic Location, Other

Release Information To options: CARTI, Other (Specify facility/individual & address below, including phone/fax if known.)

Purpose of Release

Purpose of Release options: Treatment/Continued Care, Application for Insurance, Other, Personal, Disability Determination, Legal Purposes, Payment of Insurance Claim

Information to be Released

Information to be Released table with columns: Service Dates (From, To), Information Needed By (Optional). Includes checkboxes for History and Physical, Med Onc Treatment Records, Laboratory Reports, Rad Onc Treatment Records, etc.

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