



GEORGIA CANCER SPECIALISTS

Authorization for Release of Health Information

1. I hereby authorize Georgia Cancer Specialists, I, P.C. or _____ to release the following information from the health record of: _____
(Organization Name or N/A)

Patient Last Name, First Name and MI

____/____/_____
DOB (MM/DD/YYYY)

Patient's Address:

Patient's Telephone Number:
(____)____-____ (Home)
(____)____-____ (Work)

2. Information to be disclosed (check all that apply):

- Complete Health Record Initial Visit Note Progress Note
 Laboratory Test Radiology Reports
 Other (please specify) _____

I understand that this will include information relating to (check if applicable):

- Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) Infection
 Behavioral health service/psychiatric care
 Treatment for alcohol and/or drug abuse

3. Covering the period(s) of healthcare: From (date) _____ To (date) _____

4. This information is to be released to: _____

Address: _____

- For the purpose of:** At the request of the individual Attorney Second Opinion
 Transferring Care Insurance Other _____

For all requests marked "At the request of the individual," the physician must approve request for records prior to releasing pursuant to 45 CFR § 164.524(2). We will notify you if physician refuses to release records.

5. I understand that any treatment or payment will not be conditioned upon my signing this authorization. I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization as outlined in the Notice of Privacy Practices. Unless otherwise revoked, this authorization is good for 60 days from the date of this authorization.
6. The facility, its employees, officers, and physicians will not be civilly or criminally liable for disclosure of the above information as requested.

Signed: _____ Date _____
(Patient)

Or (Legal Representative) / (Relationship to Patient) Date _____
R: 7/08