



Medical Records Release

Authorization to Use or Disclose My Health Information

(Required by HIPAA, the Health Insurance Portability and Accountability Act)

Patient name _____ Date of birth _____

My Authorization

You may use or disclose the following health care information (check all that apply)

- All my health information maintained by Central Park Hematology & Oncology
- My health information relating to the following treatment or condition _____
- My health information for the date(s) _____
- Other _____

You may release this health information to

- Myself
- Other
 - Name (or title) and organization _____
 - Address _____ City _____ State _____ Zip _____

This authorization ends

- On (date) _____
- When the following event occurs _____

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed Name (if signed on behalf of the patient)

Relationship (parent, legal guardian, personal representative, etc.)