

**PIEDMONT CANCER INSTITUTE PC**  
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

*Failure to provide all information may void this authorization*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address \_\_\_\_\_ MRN: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Release To / Request From**

- Release To **SELF** (same information as above)
- Release To Person/Organization: \_\_\_\_\_
- Request From Address: \_\_\_\_\_
- City/State/Zip: \_\_\_\_\_
- Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose of Request**

- Personal  Insurance  Other \_\_\_\_\_
- Continuing Care  Legal \_\_\_\_\_

**Information to be released (check all that apply)**

**Treatment Dates: From** \_\_\_\_\_ **To** \_\_\_\_\_

- Entire Medical Record  X-ray Reports  Other \_\_\_\_\_
- History and Physician Exam  Medication Records \_\_\_\_\_
- Office Notes  Hospital Discharge Summary \_\_\_\_\_
- Laboratory Reports  Billing Records \_\_\_\_\_

**State / Federal Laws require specific authorization to release the following types of information:**

- Alcohol/Drug Abuse  Mental Health  HIV test results

**Delivery Instructions**

- Fax records directly to ORGANIZATION specified (We do NOT fax records to patients)
- Mail records directly to person or organization specified
- In person pick-up (complete below if other than patient) Phone: \_\_\_\_\_

I authorize \_\_\_\_\_ to pick up my medical record copies.

Relationship to patient: \_\_\_\_\_ **(Note: ID IS Required)**

**Authorization Signatures**

I request Piedmont Cancer Institute, P.C. (PCI) to release my protected health information. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by our policies and applicable law unless re-disclosure specifically prohibited by law. I understand that otherwise limited by state or federal regulations, I may revoke this authorization at any time in writing, signed by me or on my behalf, and delivered to: Piedmont Cancer Institute, P.C., 1267 Highway 54 W, Ste 4200, Fayetteville, GA 30214-2112. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, PCI will continue to provide treatment and seek payment for services provided. PCI may charge a fee for providing the information specified above.

I understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here:** \_\_\_\_\_.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
Witness to Signature \_\_\_\_\_  
Date

**OFFICE USE ONLY**

Verified by:  Driver's License  Photo ID  Passport  Other \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_