

PIEDMONT CANCER INSTITUTE PC
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate/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., 1240 Eagles Landing Pkwy, Ste 260, Stockbridge, GA 30218-5173. 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: _____