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., 4877 Bill Gardner Parkway, Locust Grove, GA 30248-3644. 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:_____