



MISSOURI CANCER ASSOCIATES

Authorization to Release/Obtain Health Information

I hereby authorize/request Missouri Cancer Associates to: Release Obtain medical information regarding:

_____ (patient's full name)

Former Name(s) (if applicable): _____ Date of Birth: _____ Social Security #: _____

I request only the following information to be released:

- Psychotherapy Notes Office Notes Hospital Records Treatment Records CD of Images
- Pathology & Lab Reports Imaging Reports Genetic Information Financial/Billing Records

Other: _____ **Specific dates to be released:** _____

Method Records to be released: Paper/Mail Fax CD/Jump Drive (only certain records) Email (only certain records)

HIV/AIDS I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.
 Initial: _____ Date: _____

Release or mail to:

_____ (Individual/Physician/Institution/Agency)

_____ (Street Address/Email Address)

_____ (City, State & Zip Code)

_____ (Telephone Number) _____ (Fax Number)

For the purpose of: _____ Request Expires on: _____ (not to exceed 1 yr)

_____ (Signature of Patient) _____ (Date)

_____ (Signature of parent/legal guardian/authorized rep) _____ (Relationship to patient)

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative.

I understand that you will provide this information within 10 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

I understand that this authorization of disclosure of these records is voluntary and that I can refuse to sign this authorization. I do not have to sign this form to ensure treatment. I also understand that I may inspect or obtain a copy of the information to be disclosed per Federal Law (CFR 164-524). I understand that disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by the HIPAA confidentiality rules. If I have questions about this disclosure, I can contact the Privacy Officer Anna Ingles at (866) 724-2413.