F00073

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

ROSWELL PARK
COMPREHENSIVE CANCER CENTER
ELM AND CARLTON STREETS
BUFFALO, NY 14263

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	Medical Record #:
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	Email (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

❑ Discharge Summary ❑ Clinic Notes ❑ Operative/Procedure Reports ❑ Billing Records ❑ Radiation Notes

❑ Test Results (X-Rays, Lab/Pathology Results) Please Specify: ____________________

❑ Other Please Specify: ____________________

❑ Pathology Slides ❑ X-Ray films

How would you like your records delivered?

❑ Electronic (Email, USB, CD, Portal, Other) Please specify: ____________________ ❑ Paper

❑ Home Delivery (mailed)

❑ In-Person Pickup

Where do you want the information sent? (Fill in boxes below):

Roswell Park Comprehensive Cancer Center should provide my records to: ❑ Self ❑ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

Please print your name and sign below:

Name of Patient or Personal Representative (please print)	**Relationship (please print)**
Signature of Patient or Personal Representative	**Date / Time**

Please return completed form to:

Roswell Park Comprehensive Cancer Center Medical Records Department Elm & Carlton Streets Buffalo, NY 14263	**E-mail:** HIMMedRecReleaseofinformation@roswellpark.org **Fax:** 716-845-8394 **Questions:** 716-845-5990

Roswell Park Comprehensive Cancer Center recognizes a patient's right under HIPPA to acess copies of his/her health information. There may be charges associated with processing a request and producing requested records.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____________________

If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year.