F00073

ROSWELL PARK
CANCER INSTITUTE
ELM & CARLTON STREETS
BUFFALO, NY 14263

Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____/_____/_____

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION TO

ROSWELL PARK CANCER INSTITUTE

Date: _____/_____/_____

I authorize Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

Name: _____

Address: _____

City, State, Zip Code: _____

to furnish medical information to **Roswell Park Cancer Institute • Elm and Carlton Streets • Buffalo, NY 14263**

This information will be used for the purpose of: ❑ research ❑ continued care ❑ new patient consultation
❑ other *(please specify)*_____

Patient Access Representative Name: _____ **ext.**_____

Please check the information to be sent and include dates where possible:

❑ History and Physical	from (date)__/__/__ to (date)__/__/__	❑ Discharge Summary	from (date)__/__/__ to (date)__/__/__
❑ Operative Report	from (date)__/__/__ to (date)__/__/__	❑ X-Ray & Imaging Reports	from (date)__/__/__ to (date)__/__/__
❑ Laboratory Results	from (date)__/__/__ to (date)__/__/__	❑ Consultation Reports	from (date)__/__/__ to (date)__/__/__
❑ EKG Reports	from (date)__/__/__ to (date)__/__/__	❑ Outpatient Clinic Notes	from (date)__/__/__ to (date)__/__/__
❑ All Medical Records	from (date)__/__/__ to (date)__/__/__	❑ Pathology Report	from (date)__/__/__ to (date)__/__/__
❑ Other *(please specify)* _____			from (date)__/__/__ to (date)__/__/__

❑ **Pathology Slides and Reports** Service Date: _____ Type of Biopsy: _____

❑ **Diagnostic Imaging** ❑ X-ray films

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in #45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient Signature: _____ Date: _____/_____/_____

If patient is a minor or unable to sign:

Signed by: _____ Date: _____/_____/_____

Relationship: _____

Witnessed by: _____ Date: _____/_____/_____