F00073

ROSWELL PARK
CANCER INSTITUTE
ELM & CARLTON STREETS
BUFFALO, NY 14263
FAX: 716-845-8394

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Date: _____/_____/_____

Addressograph or Name & Date of Birth

I authorize Roswell Park Cancer Institute to furnish medical information to:

Name: _____ Telephone: (_____) _____

Address: _____

City, State, Zip Code: _____

This information will be used for the purpose of:

❑ Paper
❑ Electronic

❑ Legal Reasons
❑ Research
❑ Other, please specify: _____

❑ Continued Care
❑ Insurance

❑ Personal Use
❑ Workman's Compensation

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

❑ History and Physical	from __/__/__ to __/__/__	❑ Discharge summary	from __/__/__ to __/__/__
❑ Operative report	from __/__/__ to __/__/__	❑ X-ray and imaging reports	from __/__/__ to __/__/__
❑ Laboratory results	from __/__/__ to __/__/__	❑ Consultation reports	from __/__/__ to __/__/__
❑ EKG reports	from __/__/__ to __/__/__	❑ Outpatient clinic notes	from __/__/__ to __/__/__
❑ All medical records	from __/__/__ to __/__/__	❑ Radiation Therapy	from __/__/__ to __/__/__
❑ Other, please specify: _____			from __/__/__ to __/__/__

❑ **Pathology Slides** Service Date: ___/___/___ Type of Biopsy: _____

❑ **Pathology Reports** Service Date: ___/___/___ _____

Diagnostic Imaging ❑ X-ray films

Health Information Business Hours are 8:00 AM to 5:00 PM Monday to Friday.

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 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.

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 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. If I have questions about disclosure of my health information, I may contact the Privacy Officer or the Health Information/Medical Record Department at 716-845-5990.

Patient Signature: _____ Date: _____/_____/_____

If patient is a minor or unable to sign:

Signed by: _____ Date: _____/_____/_____

Relationship: _____

Witnessed by: _____ Date: _____/_____/_____