Patient Name: _____

Date of Birth: _____

MISSOURI CANCER ASSOCIATES

There for you, every step of the way

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please **REQUEST** Medical Information **FROM**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Please **SEND** Medical Information **TO**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

The health information will be released and/or disclosed for the following purpose(s):

☐ Treatment/Continuing Medical Care (e.g. Other Healthcare Providers, Hospital, Physicians)	☐ Legal purposes (e.g. Attorneys)	☐ Personal Use
☐ Billing or Claims	☐ Insurance (e.g. life insurance application)	☐ Disability Determination
☐ School	☐ Employment	
☐ Other, please specify:		

Check the box which type of information is to be released and/or disclosed:

☐ General Medical Information (from _____ to _____)
(includes hospital and other facility records)
☐ Information regarding Specific Treatment (from _____ to _____)
(includes hospital and other facility records)
☐ Lab Results (from _____ to _____)
☐ Genetic Testing Results
☐ Other, please specify: _____
☐ Entire medical record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).

This authorization expires on/upon _____.
(insert date or event that triggers expiration, not to exceed 1 year)

Patient Name: _____

Date of Birth: _____

MISSOURI CANCER ASSOCIATES

There for you, every step of the way

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws.

I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I understand that if I want to cancel/revoke this authorization, I must mail/fax it to the address/fax number listed below or bring a letter in person stating that I want to cancel this authorization.

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. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate.

☐ **Check if patient will pick up copies at Missouri Cancer Associates.**

_____ _____

Signature of Patient/Legal Guardian/Personal Representative Date

_____ _____

If someone else signs on behalf of the patient, state your relationship to the patient Date