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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have had the opportunity to read Personalized Hematology-Oncology of Wake Forest, PLLC's Notice of Privacy Practices (*a copy may be requested*) regarding the use and disclosure of protected health information (PHI). I understand that I may refuse to sign this authorization to release my or my child's PHI and that my refusal to sign will in no way affect treatment, payment, enrollment in a health plan, or eligibility for benefits. I also understand that my signature is required in order to complete this request.

Personalized Hematology-Oncology of Wake Forest, PLLC may use and disclose my or my child's PHI only until the expiration date or event relating to me or to my child for the specific purpose of the use or disclosure. This authorization is not a blanket permission to use and disclose PHI.

At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Personalized Hematology-Oncology of Wake Forest, PLLC's Practice Manager.

I understand that PHI used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information. At that point, the PHI may no longer be protected under federal or state confidentiality rules.

I understand that Personalized Hematology-Oncology of Wake Forest, PLLC may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

I have read and understand this information. I have received a copy of this form and I am the patient or the individual authorized to act on behalf of the patient.

Medical Record Number: (*to be filled in by practice*):____

Patient Name: ____ **Date of Birth:** _____________

Address: ____

City: _________________________________ **State:** _________________ **Zip:** ________________

Home Phone: _______________ **Cell Phone:** _________________ **Work Phone:** ________________

I hereby authorize the use and disclosure of the following protected health information (PHI) relating to me as described below.

I, (NAME) ____, hereby authorize Personalized Hematology-Oncology of Wake Forest, PLLC to release the following information:

____ Entire Chart

____ History and Present Illness

____ Progress/Clinic Notes

____ Lab and X-ray Reports

____ Pathology Reports

____ Other: ___________________________

I do ____ do not____ authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to: ____

____

____

Name of Patient (PRINT): ____

Signature of Patient: ____ **Date:** _____________

Signature of Patient Representative (PRINT): ____

Relationship of Patient Representative: ____