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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: _____________

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

Telephone Consumer Protection Act (TCPA)

I agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable.

Name of Patient (PRINT): ____

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

Signature of Patient Representative (PRINT): ____

Relationship of Patient Representative: ____

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: ____