HIPAA PRIVACY
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
(Name of patient) (Date of Birth) (Soc Sec Number)

_____ _____ _____
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

Hereby Authorize _____
(Name of person/title or facility which has health information)

To release all of my medical records including but not limited to office notes, test results, outside physician reports and chemotherapy regimens

TO: **The Oncology Institute of Hope and Innovation**
(Name of person/title or facility to receive health information)

_____ _____ _____
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the Purpose of: _____

This authorization is in effect until six months from the date of signature below at which time it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

_____ _____
Signature Date