Mid-Illinois Hematology & Oncology Associates, Ltd.

PROTECTED HEALTH INFORMATION RELEASE FORM

Patient Name: _____ Date of Birth: ____/____/_____

This authorization permits Dr. _____ to use or disclose my protected health information to the following third party or parties (please include name of facility, address & phone number):

_____

_____

_____

The information that may be used or disclosed is as follows:

_____ Address including street address, city, zip code
_____ Dates, including birth date, admission date, discharge date, date of death
_____ Telephone numbers
_____ Health plan beneficiary's numbers
_____ Office notes
_____ Hospital notes
_____ Labs
_____ Radiology, which includes, x-ray, MRI, CT, bone & PET scan

_____ Other, please specify _____

Date(s) of service for which information is requested: ____/____/_____ - ____/____/_____

The purpose of this use or disclosure is as follows:

_____

Please note:

It is the office's policy to only provide the protected health information that is ordered by our physicians. For protected health information ordered by physicians other than those affiliated with this office, you must contact that physician's office.

This authorization is valid for 3 months from the signed date at the bottom. I understand that I may revoke this authorization in writing to Mid-Illinois Hematology & Oncology Associates, Ltd. at any time during the 3 month period.

I understand that the information disclosed may be further disclosed by the above named third party or parties and that it may no longer protected by the Final Privacy Rule.

I understand that I have the right to refuse to sign this authorization and that my treatment, payment of my health care, and health care benefits will not affected if I do not sing this form.

Signed: _____ Dated: ____/____/_____

Specify relationship to, or authority to act for, Patient (if applicable): _____

Print name of individual or legal representative (if applicable): _____

Revised 12/23/10