TENNESSEE**ONCOLOGY**

a partner of OneOncology

Authorization to Release Protected Health Information (PHI)

Patient Name: _____ Birth Date: _____ Last 4 digits of SS#:_____

Address: _____ Phone #: _____

Tennessee Oncology Clinic Location: _____ Phone #: _____

I request and authorize TENNESSEE ONCOLOGY *(please select one of the following options)*:

☐ **To Release health information to:** _____

(SELF; or the Name and Address of Recipient – Specify Attorney, Insurance, etc.)

FAX #:_____ Phone #:_____ Attn: _____

☐ **To Obtain health information from:** _____

(Name and Address – Specify Hospital, Physician, etc.)

FAX #:_____ Phone #:_____ Attn: _____

Purpose: ☐ Payment or Billing ☐ Personal Use ☐ Continued Care ☐ Other _____

Information to be released: ☐ Medical Records ☐ Billing ☐ Labs ☐ Imaging ☐ Imaging Disc(s)

☐ MD Notes ☐ Procedure Notes ☐ Path Results ☐ Other: _____

Date(s) of services(s): _____ **to** _____ . _____

SEND COMPLETED DOCUMENT: email – **MedicalRecords@tnonc.com, fax – **615.550.7202** or **any clinic location****

I understand that:

- This authorization will remain in effect for **one year** after the date recorded below unless noted here _____.
- I do not have to sign this authorization in order to receive treatment, payment or to be eligible for benefits.
- This authorization can be taken back (revoked) at any time with a written request to the Privacy Officer.
- Revoking this authorization stops further disclosures but cannot undo any disclosure that has already occurred.
- Once the information is released by us to an authorized recipient, they can redisclose it and the information may no longer be protected by federal privacy regulations.
- Sending an unencrypted/unsecured email or fax poses the risk of the record being viewed by unknown persons. If you request your records to be emailed or faxed, you accept the risk.
- I also understand that my records may include information regarding the diagnosis or treatment for alcohol and/or drug abuse; psychiatric or mental illness; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information AND that I can limit the release of this type of information by contacting Tennessee Oncology Privacy Officer.

I authorize and request the disclosure of protected health information as marked above.

_____ _____

Signature of Patient or Pt. Representative *Date*

_____ _____

Printed Name of Patient or Pt. Representative *Pt. Representative Relationship*
