

TENNESSEEOncology

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 #: _____ Email _____ 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 _____

RETURN COMPLETED DOCUMENT **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

Contact Privacy Officer at 615.514.3035