Tallahassee Cancer Institute

1653 Mahan Center Blvd., Tallahassee, FL 32308
Tel: (850) 219-8000 • Fax: (850) 219-8003

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ to release information from the record of:
Name of Facility/Person

_____ : _____ : _____ as described below to
Patient Name | Birth Date | SSN/MR#

Tallahassee Cancer Institute (850) 219-8000 (850) 219-8003
Name of Facility/Person | Phone | Fax

1653 Mahan Center Blvd., Tallahassee, FL 32308
Facility/Person Address

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION): _____

_____

**Parts 1 and 2 must be completed to properly identify the records to be released.**

1. Type of records to be released **and** approximate date (s) of service (check all that applies):
   - ☐ Inpatient; Dates: _____
   - ☐ Emergency Dept; Dates: _____
   - ☐ Outpatient; Dates: _____
   - ☐ Physician Office/Clinic; Dates: _____
2. Specific information to be released (check all that apply):

| | | |
|---|---|---|
| ☐ Consultation Reports | ☐ Medical History & Physical Exam | ☐ Physician Orders |
| ☐ Discharge Summary | ☐ Medication Administration Records | ☐ Progress Notes |
| ☐ Laboratory Reports/Tests | ☐ Operative Report | ☐ Psychiatric/Psychological Evaluation |
| ☐ Mammography Report | ☐ Pathology Report | ☐ Radiology Report |
| ☐ Emergency Dept. Report | ☐ EKG Report (s) | ☐ Discharge Instructions |

☐ Other, specify: _____

**HIV, Mental Health and Drug &Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ HIV ☐ Mental Health (Psychiatric) ☐ Drug & Alcohol**

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.** If applicable, specify other expiration date/event here: _____

| Date of Signature | Signature of Patient (14 years of age of older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) | Date of Signature | Signature of Parent, Legal Guardian or Authorized Representative* (complete below) |
|---|---|---|---|
| Date of Signature | Witness/Staff Member Signature | | |

*** Authorized Representative's relationship and authority to act on behalf of patient:** _____

**ORAL AUTHORIZATION (for persons physically unable to sign)**
**NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information**

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

| Date | Witness# 1 | Date | Witness # 2 |
|---|---|---|---|