



In affiliation with UPMC Cancer Centers

The Regional Cancer Center
2500 West 12th Street Erie, PA 16505
Phone (814) 838-0445
Fax: (814) 838-0443

Authorization for Use and Disclosure of Health Information

I hereby authorize _____ to release information
Name of Facility/Person
from the record of
Patient Name; Date of Birth; Medical Record Number
as described below to:

Name of facility/person Facility address

Records are requested for the purpose of (provide detailed description):

The records to be released (identify all that apply) are (please include dates of service):

- X-ray report Lab tests Consult report
Treatment notes History & Physical examination Complete record
Follow-up (progress) Pathology
Other (specify)

I authorize the use and disclosure of the following specific health information. Check all that apply:

- AIDS/HIV Behavioral or Mental Health Alcohol and/or drug abuse Sexually transmitted disease

I understand the following:

- The protected health information disclosed by the facility/person authorized above may possibly be re-disclosed by the recipient and may no longer be protected by federal or state law.
The period of time covered by this Authorization is as indicated below. If I fail to specify an expiration date, this authorization will expire in six months from the date of signature. FROM: TO:
I have the right to revoke this authorization form at any time by sending a written request to The Regional Cancer Center Medical Record Department.
I understand my decision to revoke this Authorization does not apply to any release of my health information that has been released prior to the date of my request to revoke the Authorization.
I understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
I understand The Regional Cancer Center may require me to sign this authorization prior to receiving research related treatment solely for the purpose of creating health information for another party.
If one of the purposes of this authorization is for marketing, I understand that the person I am authorizing to use and disclose information for marketing purposes will receive either direct or indirect compensation for doing so.
I am entitled to a copy of this completed Authorization form.

Patient signature Date

The above named patient is unable to provide a signature due to

Legal representative signature Date

Relationship to patient and description of authority to act on behalf of patient:

This authorization was completed on (Date) by (Staff Person)