The Regional Cancer Center
2500 West 12th St.
Erie, PA 16505
Health Information Management Phone: 814-838-0445
Health Information Management Fax: 814-838-0443

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Rights and Responsibility

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose as stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) The Regional Cancer Center (TRCC) and its staff/employee have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My decision to revoke the Authorization does not apply to any releases of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- TRCC cannot require me to sign the Authorization in order to receive treatment.
- I am entitled to a copy of this completed Authorization form.

Protected Health Information Disclosure Statement
Notice to Accompany Disclosure of Protected Health Information

This information has been disclosed to you from records protected by Pennsylvania law and for drug and/or alcohol information, is also protected by 4PA. Code 255.5 (b) and Federal law (42 CFR Part 2). Pennsylvania and Federal laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the confidentiality of HIV related information act or by 4PA. Code 255.5 (b) and 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of drug and/or alcohol information to criminally investigate or prosecute any alcohol or drug abuse.

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Patient Name: _____ Date of Birth: _____ SSN/MR#: _____

I, or my authorized representative, authorize The Regional Cancer Center (TRCC) to ☐ release ☐ receive protected health information regarding my care and treatment as set forth below on this form.

Released ☐ **To** ☐ **From**:

Name: _____

Number / Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose (check all that apply):

☐ Continuity of Care at: Name of Facility / Practice: _____

☐ Disability ☐ Personal Use ☐ Legal: ☐ Other: _____

Parts 1, 2 and 3 of this form MUST be completed to properly identify the records to be released.

Part 1: Approximate Date(s) of Service **From:** **To:**

Part 2: Specific information to be released (check all that apply):

☐ Consults/Office Notes ☐ Medical History ☐ Laboratory Results
☐ Medication Records ☐ Treatment Documents/Notes ☐ Radiology Reports
☐ Other: _____ ☐ Radiology Images

Information in the record provided by others (check all that apply)

☐ Laboratory Results ☐ Operative Reports ☐ Correspondence
☐ Radiology Reports ☐ Pathology Reports ☐ All External Items
☐ Other: _____

Part 3:

I authorize the release of: (check all that apply) ☐ **Mental Health Information** ☐ **Drug & Alcohol Information contained in the records indicated above.**

HIV-related information and genetics information contained in parts of the records indicated above will be released through this authorization unless otherwise indicated here. ☐ **Do not release HIV-related information** ☐ **Do not release genetics information**

I understand that this Authorization is effective for a period of six (6) months from the date of the 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
If applicable, specify other expiration date/event here: _____

Date of Signature	**Signature of Patient** (14 years of age or older may authorize release of mental health information. A minor can authorize information without parental consent)	Date of Signature	Signature of Parent, legal guardian or authorized representative * (complete below)

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

☐ Parent or Legal Guardian ☐ Power of Attorney

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV Related Information of Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization.

Date of Signature _____ Witness/Signature _____