GENERATIONS
Radiotherapy & Oncology PC
at Shelby Baptist Medical Center

Authorization for Disclosure of Protected Health Information

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: **Generations Radiotherapy & Oncology PC**

B. Person(s) or Organization(s) authorized to receive the information: _____

_____

C. Specific description of the information that may be used or disclosed (including dates) _____

- ☐ Progress Notes
- ☐ Laboratory Reports
- ☐ Immunizations
- ☐ Radiotherapy Records
- ☐ History and Physical
- ☐ X-Ray Reports and Films
- ☐ Consultation Report(s)
- ☐ Other (please specify) _____

D. Specific description of how the information will be used:

- ☐ Personal Use
- ☐ Continued Medical Care
- ☐ School
- ☐ Other (please specify) _____
- ☐ Insurance
- ☐ Retirement/Separation
- ☐ Legal

1) I understand that this authorization will expire on _____ *(insert date)*.
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Generations Radiotherapy & Oncology PC in writing.
3) I understand that I can refuse to sign this authorization, and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits (if applicable).
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____
PATIENT'S SIGNATURE OR PATIENT'S REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF PATIENT'S REPRESENTATIVE RELATIONSHIP TO PATIENT

NOTE:

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/2015" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD / Research).

YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS FORM