Willamette Valley Cancer Institute and Research Center (WVCI)

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3377 RiverBend Drive, Suite 500 Springfield, OR 97477 (541) 741-3451 Fax (541) 741-5111

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

_____ _____
Patient Name **Date of Birth**

Please **REQUEST** Medical Information **FROM**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

Please **SEND** Medical Information **TO**:

_____
Person/Organization Name

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

By initialing the spaces below, I authorize the release of the specified medical records. This may include information contained in my medical record that was provided to WVCI from another health care provider or facility. Further, by signing this Authorization form, it is understood that WVCI may continue to release information or copies of medical records to the above named party, as may be requested, through the expiration date noted below.

_____ Office Chart Notes
_____ Pathology Reports
_____ Radiation Therapy Reports
_____ Consultation and H&P Reports
_____ Billing / Account Summary
_____ Laboratory Reports
_____ Hospital Reports & Discharge Summaries
_____ X-Ray Reports
_____ Medication Flow Sheet
_____ Social Work Information
_____ Entire Medical Record (including genetic testing, alcohol and/or drug use or sexually transmitted diseases).
_____ Other, Please Specify _____

I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws. I understand that I may revoke this authorization at any time by notifying the disclosing party in writing. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. **This Authorization will expire one hundred eighty (180) days from the date of signing or notification that disability benefits have ended.**

_____ _____
Signature of Patient Date

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

_____ _____
Name of Personal Representative Relationship to Patient

Distribution: Original – Medical Record **Copy To: Patient or Personal Representative**