Authorization for Release of Information

Please sign only! We will fill in the information if needed at a later time.

1. I hereby authorize _____ to release information including, if any psychiatric or psychological information, infectious or contagious disease information (including AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same) for the health records of:

Covering the periods from: _____ to: _____

Date of Birth: _____ SSN#: _____

2. Information to be released:
   - ☐ Copy of Radiation Oncology Records
   - ☐ Pathology
   - ☐ History & Physical
   - ☐ Diagnostic Reports
   - ☐ Port Films
   - ☐ Other _____

3. Information to be released to: (Please include name and address):

_____

_____

4. Purpose or disclosure _____

5. I have read and understand the Consent for Release of Radiation Oncology Records, and have voluntarily and knowingly signed such consent.

_____ _____

Signature of Patient or Representative Date