

# Authorization for Disclosure of Health Information



Patient  
ACCT#  
DOB

MDA #

Print Date  
FC SEX Location

## Outside Facilities

(1) I hereby authorize \_\_\_\_\_ to disclose the following information from the health records of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Patient Number: \_\_\_\_\_

Covering the period(s) of health care: From (date): \_\_\_\_\_ To (date): \_\_\_\_\_  
From (date): \_\_\_\_\_ to (date): \_\_\_\_\_

(2) **Information to be disclosed:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Discharge Summary       | <input type="checkbox"/> Radiotherapy Notes           | <input type="checkbox"/> Primary Medical Evaluation |
| <input type="checkbox"/> Consultation Reports    | <input type="checkbox"/> Chemotherapy Notes           | <input type="checkbox"/> X-Ray Reports              |
| <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Laboratory Tests             | <input type="checkbox"/> Nurses Notes               |
| <input type="checkbox"/> Complete Health Records | <input type="checkbox"/> Other (please specify) _____ |   |

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.

(3) **This information is to be disclosed to:** \_\_\_\_\_  
Address \_\_\_\_\_  
For the purpose of \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(4) I understand that this authorization may be revoked in writing at any time, (please see the M. D. Anderson Notice of Privacy Practices for specific details) except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_

(5) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization.

(6) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: \_\_\_\_\_  
(Patient) (Date)

OR \_\_\_\_\_  
(Personal Representative) (Relationship to Patient) (Date)

# Authorization for Disclosure of Health Information



Patient ,  
ACCT#  
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## Institutional

<b>Mail Completed Requests To:</b> Release of Information (ROI) M. D. Anderson Cancer Center 1515 Holcombe Blvd. - Unit 75 Houston, TX 77030-4009	<b>Office Use Only</b>				<input type="checkbox"/> <b>Copy to the Patient</b>
	Originating Location: <input type="checkbox"/> ROI	<input type="checkbox"/> DI	<input type="checkbox"/> Path	<input type="checkbox"/> Rad Onc	
Pick Up Location: <input type="checkbox"/> ACB ROI		<input type="checkbox"/> Main <input type="checkbox"/> Campus ROI			

(1) I hereby authorize M.D. Anderson Cancer Center to disclose the following information from the health records of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone No. \_\_\_\_\_ Patient MR#: \_\_\_\_\_  
 Covering the period(s) of healthcare: From (Date) \_\_\_\_\_ To (Date) \_\_\_\_\_

(2) Information to be disclosed: *Reports are always included with Diagnostic Images and Pathology Slides & Blocks*

<p><b>Medical Records</b></p> <input type="checkbox"/> Chemotherapy Notes <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Primary Medical Evaluation <input type="checkbox"/> Progress Notes <input type="checkbox"/> Complete Health Records <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Other: _____	<p><b>Diagnostic Imaging</b></p> <input type="checkbox"/> Original Images (Film)  <input type="checkbox"/> Copy Images ( ) Film ( ) CD-ROM	<p><b>Pathology</b></p> <input type="checkbox"/> Slides <input type="checkbox"/> Blocks <input type="checkbox"/> Reports	<p><b>Radiation Oncology</b></p> <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Simulation Notes <input type="checkbox"/> Clinic Notes <input type="checkbox"/> Treatment Record <input type="checkbox"/> External Beam Summary <input type="checkbox"/> Simulation Images <input type="checkbox"/> Port Images <input type="checkbox"/> Other: _____
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*I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing. M.D. Anderson, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.*

(3) This information is to be disclosed to: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 For the purpose of \_\_\_\_\_

(4) I understand that this authorization may be revoked in writing at any time, (please see the M. D. Anderson Notice of Privacy Practices for specific details) except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_  
(1 year from signed date)

(5) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization.

(6) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: (Patient) \_\_\_\_\_ (Date) \_\_\_\_\_

\_\_\_\_\_ (Date) \_\_\_\_\_  
*or (Personal Representative) (Relationship to Patient)*

**NOTICE: Slides; Blocks; and Original X-rays** - These materials are important to continuing care and constitute an indispensable part of a medical record, and these materials should be brought back for any future hospital or clinic visits.

### FOR OFFICE USE ONLY

Rep ID No.: \_\_\_\_\_ Rep Initials: \_\_\_\_\_ Date Completed: \_\_\_\_\_ No. of Pages/Items: \_\_\_\_\_

Personal Representative Verified: (Rep Initials:) \_\_\_\_\_

# Authorization for Disclosure of Health Information

## Patient Records Fee Schedule

Patient ,  
MDA #                      Print Date  
DOB                        FC                        SEX

Date: \_\_\_\_\_ Time: \_\_\_\_\_

The fee schedule for M. D. Anderson Cancer Center and HealthPort is as follows:

**\$1.43 per page (1-60)**  
**\$0.71 per page (61+)**  
**Plus actual postage**

This fee schedule is in accordance to *HEALTH AND SAFETY CODE, CHAPTER 241.*

I, the undersigned, understand that there will be a fee involved to obtain my records.  
I hereby agree that I have been informed of such fees by signing below.

Signature: \_\_\_\_\_

Please submit this form along with the "Authorization For Disclosure of Health Information" to Release of Information.

**Please note that records are not mailed until payment is received. Once you have received an invoice, you may mail it in or use a credit card. For credit card payments please call 1-800-367-1500.**