HIGHLANDS
ONCOLOGY GROUP

AUTHORIZATION FOR RELEASE OF INFORMATION TO HIGHLANDS ONCOLOGY

1. I, _____, hereby authorize:
   Name/Facility: _____
   Complete Address: _____
   Phone:_____Fax: _____
2. To Release to: **Highlands Oncology Group**
   Dr.:_____

3232 North,North Hills Blvd.	**OR**
Fayetteville, AR 72703	
Phone: (479)587-1700	
Fax: (479) 587-1366	
	808 South 52nd Street
	Rogers, AR 727
	Phone: (479)936-9900
	Fax: (479) 936-9944

OR

Highlands Oncology Radiation Therapy
60 E. Monte Painter Dr.
Fayetteville, AR 72703

3. Information of:
   Patient Name: _____ Medical Record #: _____
   D.O.B. OR Social Security #: _____ Phone Number: _____

4. Information is to be limited to the following **Treatment Dates** (if applicable):_____
5. Information requested to be released:
   Records from: _____ To: _____
   Office Notes Only: _____
   All Records: _____
   Other? (explain): _____

6. Purpose of release is at the request of the patient or:
   Insurance Company: _____
   Medical Care: _____
   Other? (explain): _____

7. This authorization will expire 90 days from the date on which it was signed unless I specify a different time period. Expiration Date: _____. I understand that I may revoke this authorization at any time by giving written notice. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization.

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8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws.

9. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient or Legal Representative: _____

If Legal Representative, authority of Legal Representative: _____
(such as parent of a minor,court-appointed guardian,Power of Attorney,etc.,)

Date Signed: _____