HIGHLANDS ONCOLOGY GROUP

AUTHORIZATION FOR RELEASE OF INFORMATION FROM HIGHLANDS ONCOLOGY

1. I, hereby authorize **Highlands Oncology** to release to:

   Name _____

   Phone_____ Fax_____

   Complete Address_____
   Street Address City State Zip

2. Information:

   Patient Name _____Medical Record #_____

   D.O.B. Or Social Security #_____Phone Number_____

3. Information is to be limited to the following **dates of treatment** (if applicable): _____

   _____

4. Request to be accessed or released:

   Records from: _____ To:_____

   Office Notes Only:_____ Lab Results _____ Pathology _____ Scan Results _____

   Hospital Records _____

   Records of other providers on file with H.O.G.,(if any) may not be the complete records of the other providers. If you want a complete copy of those records, you may want to contact them individually.

   I understand that if the records requested to be released include information relating to **sexually transmitted diseases, AIDS or HIV, alcohol or drug abuse, or mental health information**, a separate signed authorization will be required by the patient.

5. For clinical billing records, please contact the North Hills Billing Representative at (479) 587-1700 OR the Bentonville Billing Representative at (479) 936-9900

6. Purpose of release is, at the request of the:
   Patient_____
   Insurance Company_____
   Other Medical Facility _____
   Other Reason _____

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 to Highlands Oncology. A revocation of this signed authorization will not apply to records already released. A photocopy of this signed authorization shall constitute a valid authorization.

8. Highlands Oncology, its employees and physicians are released from legal responsibility or liability for the release of above information to the extent indicated and authorized herein.

9. 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.

10. Highlands Oncology will not condition treatment, payment, enrollment or eligibility for benefits upon signing this authorization.

Signature of Patient or Legal Representative: _____

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

Date Signed: _____

PROVIDE A COPY TO PATIENT/LEGAL REPRESENTATIVE