HIGHLANDS
ONCOLOGY

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
   ATTN: Medical Records
   3901 Parkway Circle, Suite 100
   Springdale, AR 72762
   Phone: 479-587-1700
   Fax: 479-587-0820

3. Information of:

   Patient Name: ______________________ Medical Record #: ____________

   D.O.B. ______________________ SSN: ______________________

   Mailing address :______________________________

   City______________________State________Zip____________

   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):______________________

07/2020

6. Purpose of release is at the request of the patient or:

   Insurance Company: ________

   Medical Care: ________

   Other? (explain): ________________________________

7. This authorization will expire one year 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.

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: ____________________________

For Office Use Only:

Employee Signature:____Date:______________________