Asheville Urological Associates
1 Doctors Park - Asheville, NC 28801

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(Policy 085-H09)

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Physician Location Acronym

Patient Address (Street, City, State, ZIP Code)	Patient Telephone Number

The following individual or organization is authorized to make the disclosure:
☐ 21st Century Oncology Asheville Urological Associates: Phone (828) 253-5314 - Fax: (828) 253-0434

This information may be disclosed to and used by the following individual or organization (must include name and address):

check an option ☐ obtain records from: ☐ send records to: **Physician Name/Group:** _____

Physician Address: _____ **Phone:** _____ **Fax:** _____

Treatment Dates (if applicable):	Purpose of Request:

The following information is to be disclosed: (check all that apply – must be specific)

Yes	No	
☐	☐	……..Consultation Reports
☐	☐	……Diagnostic Films
☐	☐	……Dosimetry Records
☐	☐	……Laboratory Results
☐	☐	……Physician Dictation
☐	☐	……Portal Films/Simulation Films
☐	☐	……Progress Notes
☐	☐	……Radiology or imaging reports
☐	☐	……Surgery/Pathology
☐	☐	……Complete record
☐	☐	……...Other _____
☐	☐	……Other _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event, or condition, this authorization will expire in one year.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

If I have any questions about disclosure of my health information, I can contact the 21st Century Oncology Privacy Officer at (866) 679-8944.

Signature of Patient or Legal Representative	Date

If Signed by Legal Representative, Relationship to Patient