ARIZONA ONCOLOGY

United in Healing with The US Oncology Network

HIPAA AUTHORIZATION TO USE AND DISCLOSE MEDICAL INFORMATION

I, [patient name:]_____, [Date of Birth:]_____ authorize Arizona Oncology to **use and disclose** my medical information to:

Organization Name: RECORDS DEPOSITION SERVICE, INC.

Attention: _____

Address: PO BOX 5054, SOUTHFELD, MI, 48086-5054

_____

Phone: 248-357-3330

Fax: 248-357-3337

The use and disclosure is for the specific purpose of: _____.

INFORMATION TO BE RELEASED:

_____ Provider Notes of Medical History, Examination
_____ Progress or Discharge
_____ Tests and Results
_____ Hospital Records Including Reports
_____ Radiology Reports
_____ Laboratory Reports
_____ Entire Record (specific justification) _____

_____ Surgical Reports
_____ Immunizations
_____ Allergy Records
_____ Prescriptions
_____ Consultations
_____ Other (Specify):
PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

In addition, I specifically authorize the release of records pertaining to:

_____ Mental Health
_____ HIV-related Information
_____ Genetic Information
_____ Other (Specify): _____

_____ Alcohol and Drug Abuse
_____ Other Communicable Diseases
_____ Developmental Disabilities

For The Following Date(s):

_____

HOW THIS FORM MAY AFFECT ME AND MY RIGHTS:

Right to Revoke Authorization. I understand that I have the right to revoke this authorization, except to the extent that Arizona Oncology has already used or disclosed my medical information in reliance of this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to Arizona Oncology medical records staff.

My Medical Information May Be Re-Disclosed. I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who receives my medical information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

Right to Inspect and Copy My Medical Information. I understand that I have the right to inspect and copy my medical information in Arizona Oncology records. I understand that to inspect and copy medical information, I must submit my request in writing to Arizona Oncology medical records staff. If I request a copy of the information, I understand that Arizona Oncology may charge a reasonable cost-based fee in accordance with applicable law to fulfill my request. I understand that Arizona Oncology may deny my request to inspect and copy in certain very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed in certain circumstances.

I Am Not Required to Sign this Authorization. I understand that I may refuse to sign this authorization without affecting my ability to obtain treatment at Arizona Oncology. However, I also acknowledge that I have agreed to sign this authorization.

Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

EXPIRATION DATE:

This authorization will remain in effect until the following date (or event): _____. If no date or event is specified, this authorization shall expire one year from the date this form is executed as listed below.

Signature of Patient:_____

Date:_____

Signature of Legal Representative:_____

Date:_____

If signed by a Legal Representative, **include documentation of legal authority** and complete the following:

1. The Individual is: □ a minor □ legally incompetent or incapacitated □ deceased
2. Legal authority: □ parent* □ legal guardian □ next of kin/executor of deceased
   □ activated POA for Health care

*By signing above, I hereby declare that I have not been denied physical placement of this child nor have my parental rights been terminated by court order.