THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER

Authorization for Disclosure of Health Information

Patient
MDA #
Date
DOB FC SEX

Institutional

Mail Completed Requests To:
Release of Information (ROI)
M. D. Anderson Cancer Center
1515 Holcombe Blvd. - Unit 75
Houston, TX 77030-4009

Office Use Only

Originating Location: ☐ ROI ☐ DI ☐ Path ☐ Rad Onc ☐ MCC
Pick Up Location: ☐ ACB ROI ☐ Main Campus ROI

☐ ***Copy to the Patient***

(1) I hereby authorize M.D. Anderson Cancer Center to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____
Telephone No. _____ Patient MR#: _____
Covering the period(s) of healthcare: From *(Date)* _____ To *(Date)* _____

(2) Information to be disclosed: *Reports are always included with Diagnostic Images and Pathology Slides & Blocks*

Medical Records
- ☐ Chemotherapy Notes
- ☐ Consultation Notes
- ☐ Discharge Summary
- ☐ Nurses Notes
- ☐ Primary Medical Evaluation
- ☐ Progress Notes
- ☐ Complete Health Records
- ☐ X-Ray Reports
- ☐ Other: _____

Diagnostic Imaging
- ☐ Original Images (Film)
- ☐ Copy Images
  - ( ) Film
  - ( ) CD-ROM

Pathology
- ☐ Slides
- ☐ Blocks
- ☐ Reports

Radiation Oncology
- ☐ Consultation Notes
- ☐ Simulation Notes
- ☐ Clinic Notes
- ☐ Treatment Record
- ☐ External Beam Summary
- ☐ Simulation Images
- ☐ Port Images
- ☐ Other: _____

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing. ***M.D. Anderson, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.***

(3) This information is to be disclosed to: RECORDS DEPOSITION SERVICE, INC.
Address: PO BOX 5054, SOUTHFIELD MI 48086-5054
For the purpose of LEGAL - DISCOVERY BEFORE TRIAL

(4) I understand that this authorization may be revoked in writing at any time, *(please see the M. D. Anderson Notice of Privacy Practices for specific details)* except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
(1 year from signed date)

(5) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization.

(6) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: *(Patient)* _____ *(Date)*

_____
or (Personal Representative) (Relationship to Patient) *(Date)*

NOTICE: Slides; Blocks; and Original X-rays - These materials are important to continuing care and constitute an indispensable part of a medical record, and these materials should be brought back for any future hospital or clinic visits.

FOR OFFICE USE ONLY

Rep ID No.: _____ Rep Initials: _____ Date Completed: _____

File Under: Correspondence

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