Inland Hematology Oncology Medical Group, Inc.
401-C East Highland Ave., San Bernardino, CA 92404-3875

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT'S NAME:_____ DOB:_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific description of the information to be used or disclosed including (if practicable) the dates of service(s) related to such information:

_____

_____

Specific Authorizations:

The following information will not be released unless you specifically authorize its disclosure by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis and/or treatment.

_____ I specifically authorize the release of information pertaining to mental health diagnosis and/or treatment as follows: _____

_____ I specifically authorize the release of HIV/AIDS testing information

_____ I specifically authorize the release of genetic testing information.

The following individual or organization is authorized to receive/review the above named patient's health/medical records. If records are being released for Personal use, there will be a set fee (see receptionist for details).

RELEASE RECORDS TO:

Name or Organization:_____ Phone#:_____
Address:_____ City:_____ State:_____ Zip:_____
Purpose(s) of disclosure:_____
(including any limitations on use or disclosure)_____

INFORMATION TO BE RELEASED:

_____ Medical Records _____ Labs/Pathology Slides _____ X-ray reports/Images
_____ Emergency records _____ Physical Therapy _____ Personal Records
_____Other (specify):_____

YOUR RIGHTS:

I understand that I may refuse to sign this authorization form and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf and delivered to: Inland Hematology Oncology Medical Group, Inc. 401-C East Highland Ave. San Bernardino, CA 92404. My revocation will be effective upon receipt. It is possible that the information disclosed under this Authorization could be subject to disclosure by the recipient and no longer protected by federal or state privacy laws. I have a right to receive a copy of this Authorization.

SIGNATURE

Signature of Patient/Legal Representative:_____ Date:_____
Relationship to Patient/Authority to Act for Patient:_____
Witness:_____ Identification Verified:_____
Authorization Expires (date or Event/condition):_____