Naples Cancer Advisors
Great Care Begins with a Great Plan

Authorization to Use or Disclose Protected Health Information

("Release of Information")

3201 Tamiami Trail N, Suite 112
Naples, FL 34103
Phone: (239) 846-2273 (CARE)
Fax: (513) 731-2274

This request is to release medical records for the following:

Last Name _____ First Name _____ Middle _____ Date of Birth _____

Maiden Name _____ Last 4 of Social Security Number _____ Telephone Number _____

Address (Street, City, State, Zip Code) _____

Medical records to be released FROM:

Name of Person or Organization _____

Address (Street, City, State, Zip Code) _____

Phone Number _____ Fax Number _____

Medical records to be released TO:

Name of Person or Organization _____

Address (Street, City, State, Zip Code) _____

Recipient Phone Number _____ Recipient Fax Number _____

Treatment Dates _____

☐ Self ☐ Continuity of Care / For Another ☐ Disability ☐ Legal ☐ Insurance

The following information to be disclosed (please check):	☐ Abstract ☐ Discharge Summary ☐ History and Physical examination Consultations, including psychiatric evaluations ☐ Operative report or procedure reports ☐ Emergency Department Record ☐ Laboratory reports, including drug screens	☐ Radiology or x-ray reports ☐ Interdisciplinary records (progress notes) ☐ Medication lists and documentation ☐ Nursing notes ☐ Physician orders ☐ Other _____
Sensitive Information	I understand that the information in my records may include information relating to sexually transmitted diseases. Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection. It may also include information about behavioural 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 via mailing or faxing to one of the locations listed above. I understand that 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 or when the following event or condition occurs; _____ if I do not specify an expiration date, event, or condition, this authorization will expire in 60 days.	
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. Research participation requires a separate authorization by the patient. I understand that I may inspect or obtain a copy of the information to be used or disclosed. If I have any questions about disclosure of my health information, I can contact Cincinnati Cancer Advisors by calling the number listed above.	

Print Name _____ Date _____ Time _____

Signature of Patient or Legal Representative* _____

If signed by Legal Representation, relationship to patient _____

Legal representative must provide a copy of guardianship, Executor of Estate, or Power of Attorney (POA) documents

Office Use Only: Received by _____ Medical Record number _____ Date Received _____

Copy to individual