Notice of Disclosure and Release of Information

Name: _____ Date of Birth: _____

Any person/parties requesting my protected health information that is not part of my direct medical care team, facility, or organization must be noted below. The parties listed below are authorized to receive information regarding my medical care, including coordination of care, financials, and billing information unless noted otherwise.

FIRST AND LAST NAME	RELATION TO PATIENT	DOB OR PHONE #

Notes: _____

I understand that the listed above person(s) or organization receiving my protected health information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

By signing below, I, _____, hereby authorize ***Anchorage Radiation Oncology Center***:
(Patient/Legal Guardian)

1. To request, obtain, and receive my protected health information from healthcare providers, facility, or organization involved in my direct medical care.
2. To release my protected health information to healthcare providers, facility, or organization involved in my direct medical care.
3. To release my protected health information to the parties listed above, who may not be directly involved in my medical care.

This authorization expires 1 year (365 days) from the date of my signature unless otherwise noted below. *If your care spans beyond 1 year you will be asked to complete a new form annually.*
Alternate date of expiration: _____

_____ _____
Printed Name of Patient/Legal Guardian Date

_____ _____
Signature of Patient/Legal Guardian Relation to Patient

Clinic Note: *This authorization was revoked on:* _____
(See attached revocation)