ALABAMA ONCOLOGY®

HIPAA
Authorization to Use and Disclose Protected Health Information (PHI)

NAME: _____ DATE: _____

I hereby authorize Alabama Oncology to release, discuss and/or disclose my health information to person(s) listed below.

It is my understanding that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits disclosure of my individually identifiable health information to certain personal representatives. I am signing this authorization so that Alabama Oncology can disclose my healthcare information to the individuals listed and openly discuss that information with them.

I understand that this authorization will remain in effect as long as I receive services from Alabama Oncology. I may revoke this authorization at any time and to revoke this authorization I must do so in writing. (45 CFR § 164.508)

NAME:_____ Relationship:_____ Phone: _____

NAME:_____ Relationship:_____ Phone: _____

NAME:_____ Relationship:_____ Phone: _____

NAME:_____ Relationship:_____ Phone: _____

Alabama Oncology also has my permission to obtain/release my protected health information from/to the providers listed below:

Physician/Institution Name:_____

Physician/Institution Name:_____

Physician/Institution Name:_____

Patient Signature:_____