Lee Cancer Clinic

B. Koneru M.D.
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Authorization for Release of Protected Healthcare Information

Patient Name :

Date of Birth :

Address:

City, State, zip:

Authorizes (provider)

Release of Protected Healthcare Information to (Recipient):

Lee Cancer Clinic
4755 Summerlin Rd, Suite 7, Fort Myers, FL 33919

Information to be Released

H&P, Progress reports

Lab Reports

X-rays, CT, MRI, PET scan reports

Surgical and Pathology Reports

Others

Entire Record

I understand that if the person and/or Organizations listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information may be re-disclosed without obtaining my authorization

Your rights with respect to this Authorization:

Right to Inspect or Copy the Health Information to be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting: ___________________. **Right to receive a copy of this Authorization**: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a copy of this form. **Right to refuse to sign this Authorization**- I understand that I am under no obligation to sign this form and that the persons and or organizations listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility, for health care benefits on my decisions to sign this authorization. **Right to Withdraw this Authorization**- I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal I may contact : _____________________. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person (s) and/or organizations listed above have already made in reference to this authorization.

Expiration Date: this authorization is good until the following date: ________________ or for a period of one year from the date signed.

I have had a n opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Of patient or Legal Representative: ____ Date: ______________

Signature of Witness: ____ Date : ______________