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### CANCER PARTNERS RELEASE FORM

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Following the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV\* RELATED INFORMATION** only if I authorize with my initials below.
- I have the right to revoke this authorization at any time by writing the health care provider below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary.

I hereby authorize: **Cancer Partners of Nebraska**

To release medical information to: (Name and Address/Agency requesting medical information)

Self, FMLA (relating to my care), and/or Disability paperwork:

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Include: (indicate by initialing)

\_\_\_\_\_ Alcohol/Drug Treatment Information

\_\_\_\_\_ Mental Health Information

\_\_\_\_\_ \*HIV-Related Information

\_\_\_\_\_ Genetic Testing

\_\_\_\_\_ Radiology

           Complete Medical Records

\_\_\_\_\_ Lab/Pathology Results

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ Hospital Records

\_\_\_\_\_ Correspondence

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_