Authorization to Release Medical Information to Family Members

Patient Name: ____

DOB: ______________________________ MRN: ______________________________________

I Hereby authorize medical providers and personnel of Meridian Park Radiation Oncology Center to discuss my protected information with the following people:

Name	Relationship
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

I understand that certain information cannot be released without specific authorization as required by the state or federal law. By **Initialing** the lines below**,** I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment for alcohol or drug abuse reports.

This authorization shall be in force and in effect from ____________ until __________ at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.
I understand that I have the right to revoke this authorization, in writing, at any time.
I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization.

____ ________________________________
Signature of Patient/Personal Representative Name of Patient/Personal Representative Date

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Description of Personal Representative's Authorit

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