



USA PHYSICIANS GROUP AUTHORIZATION FOR USE, DISCLOSURE, OBTAINING PROTECTED HEALTH INFORMATION (PHI) WHICH MAY RELATE TO PSYCHIATRIC, PSYCHOLOGICAL, DRUG OR ALCOHOL CONDITIONS, AND/OR DIAGNOSIS, TREATMENT OR CARE FOR HIV+, SEXUALLY TRANSMITTED DISEASE OR COMPLICATION RELATED TO SAME.

I hereby authorize USA MITCHELL CANCER INSTITUTE to disclose protected health information (PHI) from the medical record and/or financial record of:

NAME _____ DATE OF BIRTH: ___/___/___

ADDRESS _____

PHONE NO. () _____ SOC. SEC. NO. ___/___/___

Check the one that applies: USE of PHI ___ DISCLOSURE of PHI ___ OBTAINING PHI ___

PHI to be disclosed: Indicate specific inclusive dates _____

Circle if ALL or check specific items below:

- ___ Discharge Summary ___ X-ray Reports ___ Billing Records
___ Operative/Procedure Report ___ History & Physical ___ Laboratory Reports
___ Pathology Reports ___ Other (specify) _____

PHI may be disclosed to: (Include complete address)

Purpose of Use and/or Disclosure of PHI:

- ___ Attorney/Legal ___ Personal Use ___ Accident or Injury
___ Research ___ Worker's Compensation ___ Other _____

BY PROVIDING THIS AUTHORIZATION, I UNDERSTAND AS FOLLOWS:

- A) That such PHI may contain information concerning psychiatric, psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to sexually transmitted diseases, including but not limited to HIV testing and test results;
B) That the PHI to be disclosed may be subject to redisclosure by the recipient of the PHI and no longer protected by the Federal Privacy Rules;
C) That I may revoke this Authorization at any time by notifying the USA MITCHELL CANCER INSTITUTE in writing, but if I do, it will not have any effect on uses or disclosures of PHI prior to the receipt of the revocation;
D) That I may receive a copy of this Authorization form after I sign it;
E) That this Authorization will expire ___/___/___ (MM/DD/YR), not to exceed twelve (12) months, or upon the following event (if for research put "None" or "End of the research study"): _____;
F) That the employees and physicians are released from any legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signature of Patient or Patient's Legal Representative _____

Date _____

Printed Name of Patient's Representative (if applicable) _____

Representative's Relationship to Patient (if applicable) _____



RELEASE OF PATIENT PHI (PROTECTED HEALTH INFORMATION) TO
THE FOLLOWING PERSONAL REPRESENTATIVES

I, Mr. / Mrs. (First) _____, (Last) _____,
(Please Print) (Please Print) ,
authorize the University of South Alabama Mitchell Cancer Institute and its Radiation
Oncology & PET/CT Imaging departments and/or physicians to release / share my
Protected Health Information (PHI) with the following individuals listed below, regarding
my care and/or treatment.

Name of Individual #1

Relationship to Patient

Name of Individual #2

Relationship to Patient

Name of Individual #3

Relationship to Patient

Name of Individual #4

Relationship to Patient

Name of Individual #5

Relationship to Patient

May USA MCI staff and/or its Radiation Oncology Services staff leave a message on
your answering machine?

Yes No

Signature of Patient / Patient Representative

____ / _____, 20____
Date