Ironwood Cancer & Research Centers
Outsmarting Cancer One Patient at a Time™

Authorization to Release Protected Health Information

I authorize Ironwood Physicians, PC:

To use or disclose the Protected Health Information of:

Patient Name:	*Date of Birth:*

To: ☐ **From:** ☐

Name of Person or Facility:			
Address:	*City:*	*State:*	*Zip:*
Phone:	*Fax:*	*Email:*	

Requested Information

☐ Physician's Notes	☐ Laboratory Reports	☐ Radiology Reports	☐ Radiology Imaging
☐ Biopsy Reports	☐ Prescriptions	☐ Other (describe):	
For Date(s) of Service:			

Purpose of Request

☐ Personal Use	☐ Continued Patient Care	☐ Insurance	☐ Disability
☐ Legal	☐ Other (describe):		

Method of Delivery

☐ Fax	*Fax #:*	
☐ Secure Email	*Email Address:*	
☐ Mail	*Mailing Address:*	
☐ Pick Up:	*Office Location:*	*Date:*
	Name of Person (if not Patient):	
☐ Patient Portal	*Email Address for Portal Messages:*	
	Patient Portal "Terms of Service" will be presented upon Sign In	

I UNDERSTAND THAT:

The information released may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases (STDs), behavioral or mental health, alcohol and/or drug use, and genetic testing information, if any records exist.

I may revoke this Authorization at any time: The revocation will not apply to information that has already been released in response to this Authorization; I must revoke this Authorization in writing.

I may refuse to sign this Authorization: My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure. A fee may be charged for providing the protected health information.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire one (1) year from the date of signing unless an earlier date is specified in writing.

I have read and understand the information in this Authorization form

Signature of Patient:	*Date:*
Printed Name:	

OR

An authorized representative of the patient must be identified on the Consent to Release Health Information Contact Form that we have on file, or be able to provide the appropriate legal documentation to support representative status.

Signature of Authorized Representative:	*Date:*
Printed Name:	
Relationship to Patient:	

For Office Use Only: Verification of Authority				
Prepared By:	☐ HIPAA Contact List	☐ Legal Documentation	☐ Checked Fax Number/ Address	
Verified By:	☐ Picture ID	☐ Chart ID Photo	☐ HIPAA Contact List	☐ Legal Documentation