Authorization to Release, Use, and Disclose Health Information

I,_____ hereby authorize Virginia Oncology Associates to request, use, and disclose my health information in the manner described below.

I understand that Virginia Oncology Associates will use and disclose my health information as permitted by federal or state privacy laws to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), payment (including third party payers such as my insurance company), or health care operations.

I authorize Virginia Oncology Associates to **REQUEST** Medical Information on my behalf **FROM**:

Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

I hereby authorize all medical sources to release and/or disclose my entire medical record and/or my complete patient file as indicated to the Virginia Oncology Associates health care provider or representative I have indicated below.

This authorization expires upon the completion or termination of my care from Virginia Oncology Associates.

I understand that my records may contain information regarding drug, alcohol, psychological, or psychiatric conditions and communicable diseases, which are protected by federal law and cannot be disclosed without written consent, unless otherwise approved in the federal regulations. I understand that my health information may be re-disclosed by the persons or organizations receiving my medical information, and that it may no longer be protected by federal or state privacy laws. I also understand that this authorization may be revoked at any time, except to the extent action has been taken prior to revocation, by notifying the Virginia Oncology Associates in writing. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Virginia Oncology Associates will not be affected if I refuse to sign this authorization. I have read this form and/or have had it read to me and explained in a language that I can understand.

Last Name (Printed) First Middle Initial	Date Of Birth
Name Of Personal Representative (Printed)	Relationship To Patient
Patients (Personal Representative) Signature	Date

For Virginia Oncology Associates Use Only:

Please **SEND** Medical Information **TO** Virginia Oncology Associates

_____
Physician Requesting Information

Attention to: _____ Telephone: _____

Fax: _____

Address: _____

_____