Los Angeles Cancer Network
A Partner of OneOncology

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of your protected health information. Failure to provide all information requested may invalidate this authorization. By signing this document, it allows our office to communicate with and request records from your other doctors regarding your care and diagnosis. We will not share or request any information that does not specifically pertain to your treatment and care here with us at Los Angeles Cancer Network.

Patient Name: _____ Patient D.O.B: _____

USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____ to release to:

Persons/Organizations: **Los Angeles Cancer Network**

Address: _____

The following information:

a. ☐ All health information pertaining to my medical history, mental, or physical condition and treatment received OR
☐ Only the following records or types of health information (include a date range):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):
☐ Mental Health Treatment Info _____ (Initial Here)
☐ HIV Test Results _____ (Initial Here)
☐ Alcohol/drug treatment information _____ (Initial Here)

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may obtain a copy of this authorization.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  - 541 W Colorado St., Suite 205
    Glendale, CA 91204
- I may put an expiration on the authorization right now: _____

SIGNATURE

By signing this document, you are agreeing that you have read, received, and understood all parts of this document and are consenting to the use and disclosure of your medical records to our physicians so they can better serve you as a patient.

Today's Date: _____ Time: _____ ☐ AM ☐ PM

Print Name: _____ ☐ Patient ☐ Patient Representative

Signature: _____ ☐ Patient ☐ Patient Representative

If signed by a person other than patient, indicate relationship here: _____