Los Angeles Cancer Network
A Partner of OneOncology

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO FAMILY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Completion of this document authorizes the disclosure of your protected health information. Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedure, and financial information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members, you must sign this form.

Patient Name: _____Patient D.O.B:_____

USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **Los Angeles Cancer Network** to release my records and any information requested to the following individuals:

a. ☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____

b. Authorization Regarding Messages (please check all that apply)
- ☐ I authorize you to leave a detailed message on my home or cell number regarding my appointment dates & times.
- ☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information.
- ☐ I authorize you to leave a message with anyone who answers my home or cell number regarding appointment date and times.
- ☐ I authorize you to leave a message with anyone who answers my home or cell number regarding medical treatment, care, test results, or financial information.
- ☐ Messages may only be left with _____

MY RIGHTS

- Filling out and signing this document is completely optional.
- 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 (except where we have already made disclosures in reliance on your prior consent), 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 disclosure of your medical information to the persons listed above.

Print Name: _____ ☐ Patient ☐ Patient Representative **Date**: _____

Signature: _____ ☐ Patient ☐ Patient Representative **Date**: _____

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