AUTHORIZATION TO RELEASE INFORMATION

1800 N. Blanchard St. Ste., 120 Findlay, OH 45840
Phone: 419-423-0286 Fax: 888.505.2578

Patient's Name: _____

Date of Birth: _____ Phone# _____

I request and authorize

(Agency Name) _____

To release information to:

Name: Cancer Patient Services

Address: 1800 N. Blanchard St. Ste., 120

City: Findlay State: OH Zip Code: 45840

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Billing information relating to the following dates: _____

☐ Other: _____

☐ Yes ☐ No I authorize the release and disclosure of my individually identifiable health information as described above, including verbal and written exchanges about the information unless I indicate otherwise. I understand that this authorization is voluntary.

I understand that I may revoke the authorization in writing at any time, except to the extent action has already been taken in reliance on it. I understand that this authorization will expire on: _____ (specify date or event) or, if no date or event is specified, 12 month from the date of signing.

Client Signature: _____ Date signed: _____

Client Representative: _____ Date signed: _____

Relationship to Client_____

Authorization for Use and disclosure of Information