

COLORADO INTEGRATIVE CANCER CARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient's Name:		DOB			
Records to be sent to: Colorado Integrative Cancer Care Sami Diab, M.D.		Please release records from RMCC and any other medical offices and send to Colorado Integrative Cancer Care			
Provider's Address: 1400 S. Potomac Street, Suite 215 Aurora CO 80012					
Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event: No expiration date					
Purpose of Disclosure: Release records from RMCC and any other medical offices.					
Description of Information to be Used or Disclosed					
Please send all records for 2008 and 2009 and and all chemotherapy records and flow sheets.					
I understand that: <ol style="list-style-type: none"> 1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid. 164.508 (c)(1)(vi) 2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment. 3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 164.508 (c)(2)(ii) 4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 164.508 (c)(2)(i) 5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 164.508 (c)(2)(iii) 					
Section C: Required Signatures 164.508 (c)(1)(vi)					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Guardian/ or Personal Representative:				Date Signed:	
Printed Name of Patient/Guardian/ or Personal Representative:				Relationship of Personal Representative to Patient:	