

**HEMATOLOGY ONCOLOGY ASSOCIATES OF W. SUFFOLK, P.C.**  
**Authorization To Use Or Disclose Protected Health Information**

I hereby authorize use or disclosure of the named individual's health information as described below: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_ Telephone: \_\_\_\_\_

The following organization or individual is authorized to **make the disclosure**:

- Hematology Oncology Associates of W. Suffolk, P.C.
- Other (please specify): \_\_\_\_\_

This information may be **disclosed to** and used by the following individual or organization:

- Hematology Oncology Associates of W. Suffolk, P.C.
- Other (please specify): \_\_\_\_\_

**Treatment Dates:**

**Purpose of Request:**

The following information is to be disclosed: *(Please check one box for each item)*

Yes	No		Yes	No	
___	___	Physician's notes (letters)	___	___	Pathology Report
___	___	Lab Slides	___	___	Treatment notes
___	___	Lab results	___	___	Sensitive information
___	___	Genetic Testing Results	___	___	Complete record (whole chart)
___	___	Pet Scan Films	___	___	Other (please specify): _____
___	___	Diagnostic Reports (including: X-ray, CT, Bone Scan, Muga, MRI, PET, etc)			

**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

**Redisclosure:** I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information then may not be protected by federal confidentiality rules.

**Right To Revoke:** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

**Other Rights:**

- a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.
- b) I understand that I may inspect or obtain a copy if the information to be used or disclosed.

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)* To Expire On: \_\_\_\_\_

**Signature of Patient** or Legal Representative: \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_