



Winning the fight against cancer, every day.®

Cancer Treatment Centers of America® at Western Regional Medical Center

# Authorization to Use and Disclose Protected Health Information

Please use a pen to complete all sections of this form.

Patient Name (Last, First, Middle)

Date of Birth

Social Security Number

Patient's Address

City, State

Zip Code

Phone Number

**Notice to Patient:** Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

**The information authorized for release may include information which may be considered a communicable or venereal disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

**Fax to (623) 321-1565.**

I hereby authorize Cancer Treatment Centers of America® (CTCA) at Western Regional Medical Center to obtain information from:

All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities.

**Information released from providers listed above should be sent to CTCA at Western Regional Medical Center, 14200 West Fillmore Street, Goodyear, AZ 85338 ~ New Patient Intake Coordinator, telephone (623) 207-3353 or (623) 207-3354, or faxed to (623) 321-1565. For scheduling questions, call our hotline (866) 993-2778.**

This consent is allowed to be acted upon up to one year from the date of signature, unless a shorter time is specified by the patient or their representative. This authorization will remain in effect until the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ or until the following event occurs \_\_\_\_\_

I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity, and release CTCA at Western Regional Medical Center, its agents and employees from any liability in connection with the release of information contained therein. I understand that I may at any time make a written request to inspect and/or obtain a copy of my health information and that CTCA at Western Regional Medical Center will, within 45 days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any) and instructions as to how and to whom I may register a complaint regarding the denial. I may contact the Privacy Office at CTCA at Western Regional Medical Center by mail at the address above or by telephone at (623) 207-3080.

Specify information to be disclosed for treatment dates \_\_\_\_\_ to \_\_\_\_\_

The information disclosed will be limited to the following as marked:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> EEG               | <input type="checkbox"/> Naturopathic Notes | <input type="checkbox"/> Radiation Therapy     |
| <input type="checkbox"/> History & Physical   | <input type="checkbox"/> EKG               | <input type="checkbox"/> Medication Summary | <input type="checkbox"/> Records & Notes       |
| <input type="checkbox"/> Oncology Records     | <input type="checkbox"/> ER Reports        | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Rehabilitation Notes | <input type="checkbox"/> Abstract of Chart | <input type="checkbox"/> Chemotherapy       | _____  |
| <input type="checkbox"/> Operative Reports    | <input type="checkbox"/> Imaging Reports   | <input type="checkbox"/> Chemotherapy       | _____  |
| <input type="checkbox"/> Pathology Reports    | <input type="checkbox"/> and Films         | <input type="checkbox"/> Chemotherapy       | _____  |
| <input type="checkbox"/> Pathology Slides     | <input type="checkbox"/> Consultation      | <input type="checkbox"/> Records            | _____  |

## Highly Sensitive Information:

By **initialing the blank** next to a category of highly sensitive information listed below, I specifically authorize the use and/or disclosure of the indicated category, if any such information exists:

- |   |  |
|---|--|
| _____ Mental Illness or Developmental Disability            | _____ Sexual Assault   |
| _____ Psychotherapy Notes (requires provider consent)       | _____ Child Abuse and Neglect  |
| _____ Substance Abuse or Diagnoses (e.g., alcohol or drugs) | _____ Sexually Transmitted Disease   |
| _____ Genetic Testing                                       | _____ HIV/AIDS testing or treatment  |
| _____ Abuse of an Adult with Disability                     | (including the fact that an HIV test was ordered, performed or reported regardless of the results) |

For the following purpose and that purpose only:

- Continued Treatment     Personal     Other (specify) \_\_\_\_\_

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my protected health information. By my signature, I hereby knowingly and voluntarily authorize CTCA at Western Regional Medical Center to use or disclose my health information in the manner as described above.

Patient Signature (If patient unable to sign, indicate reason (e.g., minor or medically incapacitated)) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian/Other Legal Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Provide copy of legal document and specify relationship to patient.)

Witness (Witness signature required for release of information about a mental illness.) \_\_\_\_\_ Date \_\_\_\_\_