



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

Medical Record No. _____

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.

Notice to Recipient of Copies of Medical Records: PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A General Authorization for the release of Medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$5,000 in the case of each subsequent offense.

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"/> Imaging Films/
Electronic Media | <input type="checkbox"/> Chemotherapy
Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> ER Report | <input type="checkbox"/> Consultation | <input type="checkbox"/> Photographs |
| <input type="checkbox"/> Oncology Flowsheet | <input type="checkbox"/> Imaging Report | <input type="checkbox"/> Naturopathic Note | <input type="checkbox"/> Radiation Isodose
Plans |
| <input type="checkbox"/> Rehabilitation Note | <input type="checkbox"/> EKG | <input type="checkbox"/> Medication Summary | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> End of Radiation
Treatment Notes | <input type="checkbox"/> Pathology Slides | <input type="checkbox"/> Radiation Simulation
delineating all portals | _____ |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Abstract of Chart | <input type="checkbox"/> Laboratory Report | _____ |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Radiation Treatment
Cards | | |

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

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 _____