

Winning the fight against cancer, every day.®

Cancer Treatment Centers of America® at Southeastern Regional Medical Center

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

Dationt Name (Last First Middle)
Patient Name (Last, First, Middle)
Date of Birth
Date of Birth
Social Security Number
Social Security Number
Patient's Address
Tallett's Address
City, State
city, state
Zip Code
_p
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

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 (770) 400-6801.

Authorization Form

I hereby authorize Cancer Treatment Centers of America® (CTCA) at Southeastern 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 Southeastern Regional Medical Center, 600 Parkway North, Newnan, GA 30265 ~ New Patient Intake, telephone (770) 400-7060, or faxed to (770) 400-6801.

This consent is allowed to be time is specified by the patierday of	nt or their representative		ain in effect until the	
I understand this authorization has already been taken in relia information in my medical rec Southeastern Regional Medic release of information contain inspect and/or obtain a copy Center will, within 45 days of rarrange for a convenient time denial of the request that state and to whom I may register a Southeastern Regional Medic	ance on it. With this known cords including any informal Center, its agents and used therein. I understance of my health information eceiving such written reto inspect and/or copy es the basis for the denial complaint regarding the	wledge, I give my consent to mation concerning my iden employees from any liability d that I may at any time maken and that CTCA at Southeas quest, either grant the reque my health information or proal, my review rights (if any) are denial. I may contact the P	the release of all tity, and release CTCA at in connection with the e a written request to tern Regional Medical est and contact me to ovide me with a written and instructions as to how rivacy Office at CTCA at	
Specify information The information disclosed wil			atesto	
☐ Discharge Summary ☐ History & Physical ☐ Oncology Records ☐ Rehabilitation Notes ☐ Operative Reports ☐ Pathology Reports	I EEG I EKG I ER Reports I Abstract of Chart I Imaging Reports and Films I Consultation	□ Naturopathic Notes □ Medication Summary □ Laboratory Reports □ Chemotherapy Flowsheet □ Chemotherapy Records	☐ Radiation Therapy Records & Notes ☐ Other (specify)	
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 ☐	' '	(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 Southeastern Regional Medical Center to use or disclose my health information in the manner as described above.				
Patient Signature (If patient una	ble to sign, indicate reason	(e.g., minor or medically incapac	itated)) Date	
Parent/Guardian/Other Legal (Provide copy of legal document a	Representative and specify relationship to p	atient.)	Date	
Witness (Witness signature requi	Date			

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