THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER

Authorization for Disclosure of Health Information

Patient ,
MDA # Print Date
DOB FC SEX

Outside Facilities

(1) I hereby authorize ______________________ to disclose the following information from the health records of:

Patient Name: ______________________ **Date of Birth:** ______________
Address: ______________________ **City, State, Zip:** ______________
Telephone: ______________________ **Patient Number:** ______________

Covering the period(s) of health care: From *(date)*: ______________ To *(date)*: ______________
From (date): ______________ to (date): ______________

(2) **Information to be disclosed:**

- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Complete Health Records
- ☐ Radiotherapy Notes
- ☐ Chemotherapy Notes
- ☐ Laboratory Tests
- ☐ Other *(please specify)* ______________
- ☐ Primary Medical Evaluation
- ☐ X-Ray Reports
- ☐ Nurses Notes

I understand that this may include information relating to acquired immunodeficiency syndrome *(AIDS)* or infection with HIV (*Human Immunodeficiency Virus),* psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.

(3) **This information is to be disclosed to:** ______________________
Address ______________________
For the purpose of ______________________
____
____

(4) I understand that this authorization may be revoked in writing at any time, *(please see the M. D. Anderson Notice of Privacy Practices for specific details)* except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________

(5) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization.

(6) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: ______________________
(Patient) *(Date)*

____
OR *(Personal Representative)* *(Relationship to Patient)* *(Date)*