Attending Physician: _____ *Medical Record Number:_____*

Cancer Care Center

Cancer Care Center of Jackson	Cancer Care Center of Dyersburg	Cancer Care Center of Henry County	Cancer Care Center of Union City
322 Hospital Boulevard	440 Wilkinson Drive	1209 Kelley Drive	1209 Reelfoot Avenue
Jackson, TN 38301	Dyersburg, TN 38024	Paris, TN 38242	Union City, TN 38261

Authorization for Use or Disclosure of Health Information

Patient Name (please print):_____Date of Birth: _____
Address: _____Telephone Number:_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

- **Doctor's History and Physical Dictation**
- **Surgery report**
- **Path Report**
- **Recent Labs**
- **All x-ray reports**
- **CT Scans specific:_____**
- **Other:_____**

The above information can be called "Authorized Information" throughout the rest of this form.

Facility, Persons, or Class of Persons Authorized to Make the Use or Disclosure of Authorized Information:

_____

Facility to Whom the Use or Disclosure of Authorized Information May be Made (circle one):

Cancer Care Center of Jackson	Cancer Care Center of Dyersburg	Cancer Care Center of Henry County	Cancer Care Center of Union City
322 Hospital Boulevard	440 Wilkinson Drive	1209 Kelley Drive	1209 Reelfoot Avenue
Jackson, TN 38301	Dyersburg, TN 38024	Paris, TN 38242	Union City, TN 38261

Authorized Information will be used and/or disclosed for continuation of treatment, payment, or health care operations.

- **I understand that if the person or entity receiving Authorization Information is not a health plan or health care provider covered by federal privacy regulation, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I may revoke this authorization in writing any time by notifying Cancer Care Center in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cancer Care Center before receiving my revocation.**
- **I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility of benefits.**

NOTICE TO RECEIVING AGENCY OR INDIVIUAL: THIS INFORMATION IS TO BE TREATED IN ACCORDANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY REGULATIONS.

Signature of Patient (or Patient Representative, state relationship if applicable)

Name: _____Date:_____

This authorization shall be valid for one year from the date of signature.