

Attending Physician: _____

Medical Record Number: _____

Cancer Care Center

322 Hospital Blvd. Jackson, TN 38305
1-800-870-5471 or 668-1668
Fax: 731-668-5801

440 Wilkinson Dr. Dyersburg, TN 38024
1-888-748-8511 or 285-2211
Fax: 731-285-8222

1290 Kelley Dr. Paris, TN 38242
1-800-221-0948 or 644-3522
Fax: 731-644-2806

1209 Reelfoot Ave. Union City, TN 38261
1-888-941-8611 or 731-884-8611
Fax: 731-884-8443

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
322 Hospital Boulevard
Jackson, TN 38301

Cancer Care Center of Dyersburg
440 Wilkinson Drive
Dyersburg, TN 38024

Cancer Care Center of Henry County
1209 Kelley Drive
Paris, TN 38242

Cancer Care Center of Union City
1209 Reelfoot Avenue
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 INDIVIDUAL: 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.