AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ _____to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____ _____

Description of information to be released:

☐ **All** my health information as described above, unless specifically excepted: _____

_____

_____

The reason or purpose of the use and/or disclosure: _____

_____

_____

_____

The health information described herein shall be released to:

Southwest Hematology Oncology
11209 N. Tatum Blvd. #260
Phoenix, AZ 85028
Fax: 602-494-6803
Phone: 602-494-6800

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify by date or by an event. I desire this authorization to be in effect until _____ _____.
Expiration event/date

I further understand that I may revoke this authorization at any time by notifying _____ _____. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient's Representative

_____ _____
Relationship to Patient OR Legal Authority
(attach supporting documentation)