

# AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION – MEDICAL CONTACTS



Proton Therapy Center

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**FOR OFFICE USE ONLY  
AFFIX PATIENT LABEL HERE**

I authorize the IU Health Proton Therapy Center to exchange information with the physicians listed below:

Physician Name	Facility/Group Name Street Address City, State, Zip	Phone and Fax Numbers	Medical Specialty
		Phone _____ Fax _____	
		Phone _____ Fax _____	
		Phone _____ Fax _____	
		Phone _____ Fax _____	

The following information may be shared with those authorized above:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> <b>Entire Record</b> | <input type="checkbox"/> Emergency Record   | <input type="checkbox"/> Lab Report              | <input type="checkbox"/> Radiology Films/Reports |
| <input type="checkbox"/> Consultation Report  | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pathology Report/Slides | <input type="checkbox"/> View Record Only        |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Operative Report   | <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Other _____             |

I understand if all items above or entire record are checked, the requesting person(s) may receive the complete contents of my record; and IU Health Proton Therapy Center cannot under a full release take responsibility for the disclosure of this information. It is assumed by IU Health Proton Therapy Center that the parties to whom information is released will be discrete in disclosing information to the client. I understand that I have the right, with permission from my physician, to inspect and copy information to be disclosed. I understand this authorization will expire **180** days from date written below.

Dates of service for which release is approved \_\_\_\_\_  All Service Dates

This release is for:  Further Treatment  Insurance  Military  Personal Information  Legal  School

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services. I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. This authorization must be signed by the patient or guardian if the patient is a minor, physically or mentally incapacitated. A photocopy/fax of this form is as valid as the original. Federal law prohibits release of confidential information by the receiving agency according to federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records (42CFR Part 2). The law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship  Parent  Legal Guardian  Court Appointed Representative  Other \_\_\_\_\_

IU Health Proton Therapy Center Staff Signature \_\_\_\_\_ Date \_\_\_\_\_