Standard Authorization of Use and Disclosure of Protected Health Information

I, ____ DOB: ________________, authorize the Cancer Center at Metro Health Village to release/disclose any information to:

1. ____
(Name) (Relationship to patient) (Phone number)

2. ____
(Name) (Relationship to patient) (Phone number)

3. ____
(Name) (Relationship to patient) (Phone number)

4. ____
(Name) (Relationship to patient) (Phone number)

5. ____
(Name) (Relationship to patient) (Phone number)

This authorization is valid unless revoked or terminated by the patient or the legal representative of the patient.

____ ___________________AM/PM
(Signature of patient or legal representative giving consent) (Date/Time)

____ ___________________AM/PM
(Witness) (Date/Time)