AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Completion of this document authorizes the disclosure and/or use of individually identifiable protected health information, as set forth below, consistent with Federal and/or state law as applicable concerning the privacy of such information.

Patient Name: ___________________________ DOB: ________ MR# __________________

I hereby authorize release/disclosure of my protected health information by:

______________________	______________________	______________________
(Primary Oncologist)	(Secondary Oncologist - if Any)	(Additional Care Provider – if Any)
(Facility Name)	(Facility Name)	(Facility Name)
(Telephone Number)	(Telephone Number)	(Telephone Number)

I hereby authorize release/disclosure in accordance with attached instructions, of the following information:

Consultation(s)	History & Physical(s)	Pathology Report(s)
Discharge Summary(s)	Lab Reports	Progress Notes
Emergency Record(s),	Operative Reports(s)	Treatment Plans
Radiology/Imaging Reports		

From my medical records to:

LIFETRUST, LLC *
5300 Town & Country Blvd., Suite 160
Frisco, Texas 75034
Phone: (877) 565-6616 Fax: (214) 469-2037

* **And/or LIFETRUST, LLC and its duly authorized representatives, at my request for their use in evaluating or providing services for me**

The purpose for which I authorized this disclosure:

☐ **Medical Care** ☐ **Insurance** ☐ **Disability Determination** ☑ **Other:** ***Financial Services***

This Authorization shall remain in effect for twenty-four (24) months from the date indicated and signed below.

NOTICE OF RIGHTS AND OTHER INFORMATION

1. I understand that I may revoke this Authorization at any time in writing. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted upon this Authorization.
2. This Authorization specifically **DOES NOT** request release of Mental Health Treatment Information, Drug/Alcohol Treatment Information and HIV test results.
3. The information disclosed pursuant to this Authorization, ***except*** information protected by Federal and/or State regulations about confidentiality of drug and alcohol treatment records, HIV and Mental Health treatment records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.
4. My medical records may contain genetic testing information including test results.

______________________________ ______________________________ __________

Signature of patient/personal representative (e.g., legal guardian, power of attorney, etc.) | Print Name of Signor | Date

If Personal Representative: ______________________ ______________________

Relationship to Patient | Authority to Act on Behalf of Patient