Authorization for Release of Medical Records

I,____________________________________, authorize all entities that share in my medical treatment to furnish Illinois CancerCare with all personal health information and medical records, including those related to mental health, developmental disability, substance abuse, HIV/AIDS, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I also authorize Illinois CancerCare to release any personal health information and medical records about me to other health care providers, insurance companies, or other third party payors necessary for Illinois CancerCare to provide treatment, payment, or health care operations related to my care, including those records related to mental health, developmental disability, substance abuse, HIV/AIDs, sexually transmitted diseases, sexual assault, child abuse and neglect, abuse of an adult with a disability, and genetic testing.

I understand that this authorization shall be in force until revoked by me in writing or a new one signed. A photocopy of this authorization shall be as valid as the original. I understand that to revoke this authorization I must provide written notice to Illinois CancerCare, Attention Chief Privacy Officer at 8940 N Wood Sage Rd, Peoria, IL 61615.

Date of Birth:_____________________________ SS#:____________________________________

Signature: _____________________________________ Date: _____________________________

If signed by an authorized representative of the patient, please indicate relationship to patient (e.g. spouse):

Relationship: _____________________________ Witnessed by:_____________________________