



**CONSENT TO OBTAIN MEDICAL INFORMATION  
AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

- I understand that Blue Ridge Cancer Care will use and disclose my health information as permitted by federal or state privacy laws to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), payment (including third party payers such as my insurance company), or health care operation and for other purposes as described more fully in the Notice of Privacy Practices, which as been provided and acknowledged by me.
- I authorize Blue Ridge Cancer Care to REQUEST medical information on my behalf from:  
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf.
- I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45CFR Part 2). The Federal rules prohibit BRCC from making any further disclosure of this information unless further disclosure is expressly permitted by the patient.
- I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked.
- This authorization expires upon the completion or termination of my care from Blue Ridge Cancer Care.

**Information to be released:**

\_\_\_\_\_ Clinical Progress Notes                      \_\_\_\_\_ Lab Reports                      \_\_\_\_\_ CT Scans  
\_\_\_\_\_ Pathology Reports                      \_\_\_\_\_ All Hospitalization Records                      \_\_\_\_\_ Radiology Reports  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

Information to be released to: **Blue Ridge Cancer Care, 2013 South Jefferson St., Roanoke, VA 24104**

**Please fax information to** \_\_\_\_\_ **Attn:** \_\_\_\_\_

**Physician name** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient                      Date**

\_\_\_\_\_  
**Signature of Guardian or Witness                      Date**