Use this form to request patient records from an outside physician or medical practice. Obtain patient's signature prior to sending to physician office.

PATIENT REQUEST FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Name:	**Date of Birth**

Address (Street, City, State, Zip Code)	**Telephone Number**

The following individual or organization is authorized to make the disclosure:

This information may be disclosed to and used by the following individual or organization:

The following information is to be disclosed:
(describe the information to be disclosed in a specific and meaningful fashion)

__ Physician Dictation
__ Dosimetry Records
__ Radiology Reports
__ Diagnostic Films (describe) ____
__ Laboratory Results
__ Consultation Reports
__ Surgery/Pathology
__ Portal Films/Simulation Films
__ Other (describe)____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Signature of Patient or Authorized Representative	**Date**

If Signed by Legally Authorized Representative, Relationship to Patient