Low Country Cancer Care ASSOCIATES P.C.

O. George Negrea M.D.
Jennifer Yannucci M.D.

Instructions for Completing Authorization to Release Health Care Information to Third Parties

This form is to be filled out if the heath care record of a patient is to be transferred for the purpose of (i) at the request of the individual patient or authorized representative, (ii) transferring care, (iii) Insurance (iv), attorney, (v) second opinion, or another specified purpose.

To protect the privacy of our patients and to maintain the confidentiality of their personal health information, we must obtain a valid, complete and legible authorization to disclose personal health information.

1. Patient: Print the patient's - Full, legal name

- Birth date
- Maiden &/or any previous names is to be noted if applicable
- Patient's address and phone number (if we have questions)

2. Type of information to be disclosed: Accurately check/print the type of information and dates (where appropriate) that is to be released.

3. Chose the covering time period(s) of heath care records to be authorized for release to a third party

4a. This information may be disclosed to: Print the Name of the Person or Organization who is to receive the information, along with their full/complete address, city and state.

4b. This disclosure is authorized for the purpose of: Write in the Purpose for the release, i.e. transferring care; personal; etc.

5. The information is to be: Check the box if you want the information to be mailed, or if the patient/authorized designee will pick it up.

If information will be picked up, LCCC staff will contact you when it is ready. The patient's identity will be verified via driver's license or social security number. Only the patient may pick up the information, unless the patient authorizes in writing that another person may pick up the information.

6. There may be a possible charge/fee for the copies of the health information.

The patient or legal representative must sign and date the authorization. (If legal representative, a copy of verification documentation will be needed along with the authorization.)

Mail or fax the authorization to:

Lewis Cancer and Research Pavilion
225 Candler Drive, Suite 201
Savannah, Georgia 31405

Phone (912) 692-2000
Fax (912) 692-2100

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If assistance is needed in completing this form, you may contact the LCCC staff

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Authorization for Release of Health Information to Third Parties

1. I hereby authorize Low Country Cancer Care Associates P.C. or _____ to release the following information from the health record of: **(Organization Name or Not Applicable)**

   _____ ___/___/_____
   Patient Last Name, First Name and MI DOB (MM/DD/YYYY)

   Patient's Address: Patient's Telephone Number:
   _____ (_____)_____-_____ (Home)
   _____ (_____)_____-_____ (Work)

2. Information to be disclosed (check all that apply):

   □ Complete Health Record □ Initial Visit Note □ Progress Note
   □ Laboratory Test □ Radiology Reports
   □ Other (please specify) _____

   I understand that this will include information relating to (check if applicable):
   - ❑ Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) Infection
   - ❑ Behavioral health service/psychiatric care
   - ❑ Treatment for alcohol and/or drug abuse

3. Covering the period(s) of healthcare: From (date)_____ To (date) _____

4 This information is to be released to: _____
   Address: _____
   _____

   For the purpose of: □ At the request of the individual □ Attorney □ Second Opinion
   □ Transferring Care □ Insurance □ Other _____

   For all requests marked "At the request of the individual," the physician must approve request for records prior to releasing pursuant to 45 CFR ξ 164.524(2). We will notify you if physician refuses to release records.

5. The information is to be: □ Mailed □ Picked up by patient/authorized designee □ Other:_____

6. Patient was informed that there may be a possible charge/fee for the copies of their records. □ Yes □ No

7. I understand that any treatment or payment will not be conditioned upon my signing this authorization. I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization as outlined in the Notice of Privacy Practices. Unless otherwise revoked, this authorization is good for 60 days from the date of this authorization.

8. The facility, its employees, officers, and physicians will not be civilly or criminally liable for disclosure of the above information as requested.

Signed: _____ Date _____
(Patient)

_____ Date _____
Or (Legal Representative) / (Relationship to Patient)

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