HOAA

HEMATOLOGY & ONCOLOGY
ASSOCIATES OF ALABAMA, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I. Information about the Use or Disclosure.

I authorize and direct _____ (the "Practice") to disclose my health information to **Hematology & Oncology Associates of Alabama, LLC,** specifically to

1 – Allen Yeilding, MD 2 - Khaleel Ashraf, MD 3 – Mark Bridges, MD 4-David Mooney, MD

If you could please **FAX** my requested health information to HOAA at 877-353-3589

If you have any **QUESTIONS** specific to this medical records request, call HOAA 205-502-4700

The specific purpose of this Authorization is as follows: At the request of the patient

II. Information to be disclosed. This Authorization permits Practice to disclose the following medical records and information:

❑ All of my health information that Practice has in its possession, custody or control.

❑ All of my health information described above except for the following: _____

❑ Only the following records or types of health information (Insert dates of treatment, types of treatment or other designation): _____

III. Term. Unless otherwise revoked, this Authorization will expire one year from the date of authorization written below. Any revocation of this Authorization will be effective immediately upon Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by Practice in reliance on this Authorization before it received my written notice of revocation.

IV. Your Rights With Respect to this Authorization.

I understand that once Practice discloses my health information to the recipient identified above, Practice cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by Practice.

I may contact the Practice Administrator for answers to my questions about the privacy of my health information at 513 Brookwood Blvd Ste 275 Birmingham, Alabama, or by telephone at 205-502-4700.

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO THE EXTENT AND FOR THE PURPOSE STATED ABOVE.

Signature of patient or patient's representative _____ Date: _____

Printed name of the patient's or patient's personal representative: _____

Birth date of patient: _____ Patient telephone number: _____

Relationship to the patient, including authority for status as representative: _____