REQUEST FOR RELEASE OF RECORDS

Patient Name: _____DOB:_____/_____/_____

I,_____, request a copy of my complete medical record from the office of:

_____

Name and Address of Practitioner

_____

To be sent to Regional Cancer Care Associates:

_____

Address, City State Zip Code

_____

Fax/Telephone Number

_____I give permission to fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

_____

Provide office fax number

It is my understanding that by signing this authorization for release of my records, I am giving permission for Regional Cancer Care Associates to receive copies of any medical, psychiatric, AIDS, AIDS-related syndromes, HIV testing, alcohol and/or drug abuse-related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire one (1) year after the date below or sooner at my election.

_____ _____

Print Patient Name & Date of Birth Date

_____ _____

Signature Patient, Parent, or Legal Guardian/Representative Date

_____ _____

Witness Date

Regional Cancer Care Associates LLC ("RCCA") is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by RCCA after April 13, 2013.