CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name			MRN
Address			Date of Birth
City	State	Zip Code	Phone

I AUTHORIZE CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES (COHA) TO SHARE MY HEALTH INFORMATION:

List the amount or type of information you would like to share in the section below. For example, you can say, "All health information" or list certain types of information you would like to share.

_____

_____

_____

_____

CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES (COHA) MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON(S) OR ORGANIZATIONS:

Name	
Relationship	
Address	
Phone	

Name	
Relationship	
Address	
Phone	

Name	
Relationship	
Address	
Phone	

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment, or eligibility of benefits.
- Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases, HIV, or AIDS may be shared only if I initial here. _____
- If I authorize the release of substance abuse disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.

- Other types of information shared under this authorization may be re-disclosed to the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on:

  _____

  _____

(Authorization will expire one year from the signature date if you leave this blank)

Signature	Date

For Internal Use Only

COHA Staff	Date