NueVida Oncology

A division of NueVida Physician Group | 9305 Pinecroft Dr, Suite 305, The Woodlands, TX 77380 | Phone (281) 555-0148 | Fax

Authorization for Release of Protected Health Information (HIPAA)

1. Patient information

Patient full name _____ **Date of birth** _____

Phone _____ **Email** _____

Address _____

2. I authorize NueVida Oncology to release my records TO

Name / practice / organization _____

Address _____

Phone _____ **Fax** _____

3. Information to be released (check all that apply)

- ☐ Complete medical record
- ☐ Visit notes / consult reports
- ☐ Lab and pathology results
- ☐ Imaging reports
- ☐ Treatment / chemotherapy summary
- ☐ Billing records
- ☐ Other: _____

Dates of service: from _____ to _____ Purpose: [ ] continuing care [ ] personal [ ] legal [ ] other _____

I specifically authorize release of (initial to include): ____ mental health ____ substance use ____ HIV/AIDS ____ genetic testi

4. Your rights

- This authorization expires one year from the date signed unless a different date is written here: _____.
- You may revoke this authorization at any time by notifying NueVida Oncology in writing, except where action has already been taken in r
- Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this authorization.
- Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy ru
- Copies provided to treating physicians are free of charge; personal copies may carry a reasonable, state-allowed fee.

5. Signature

Signature of patient or legal representative _____ **Date** _____

Printed name _____ **Relationship to patient (if representative)** _____

Return completed form by fax to (281) 555-0149, through the Wavera Patient Portal, or in person at the front desk. Office use: received _____ by