CAPITAL REGIONAL
CANCER CENTER

Patient Label

Authorization of Disclosure of Health Information to Family Members and Others

I authorize my healthcare Information to be disclosed for purposes of communicating results, findings and care decisions to any family member or others responsible for my care listed below. I understand these individuals will be required to provide the three forms of verification outlined below before the center will release any information:

a. Last four digits of patients social security number and
b. Date of birth and
c. Any one of the following: Account number, street address, insurance carrier or insurance policy.

Individual's Name	Relationship to Patient	Phone Number

I understand my protected health information will be shared with the above listed individuals for purposes of communicating results, findings and care decisions until such time I revoke the authorization.

Patient Name:____ **Date of Birth**_______________

Patient Signature: ____**Date** _________________________

To be used only when revoking Disclosure of Health Information to Family Members and Others

I hereby revoke the above Authorization of Disclosure of Health Information to Family Members and Others and understand my PHI **will not be** communicated to the individuals listed above as of the date signed below. I understand releases that have already been made under the prior permission are not applicable under this form.

Patient Name:____ **Date of Birth**_______________

Patient Signature:____**Date**_________________________

For Facility Use Only:
Date revocation notated in paper medical record ____________________
Date revocation notated in electronic record _______________________
Name of individual notating medical record _______________________
Signature of individual notating revocation in medical record ___________________________________

Capital Regional Cancer Center
2003 Centre Pointe Blvd. Tallahassee, FL 32308
Phone:850-878-2273 Fax: 850-671-5900