START CENTER FOR CANCER CARE
A Partner of OneOncology

Authorization to Disclose Health Information

FRM-HIM-ROI-001 Rev. 2.0

Please print clearly in blue or black ink, or complete this form on screen.

SECTION A. PATIENT IDENTIFICATION

Patient Last Name	First Name	Middle Initial	Date of Birth (DD/MM/YYYY)

Street Address	City, State, ZIP	Phone

SECTION B. WHAT WILL BE RELEASED, AND TO WHOM

Complete every line that applies. START cannot process an authorization that is incomplete, unsigned, or undated. List only the people and organizations you want to receive your records.

Direction of release	Purpose of the disclosure

Physician, Clinic or Organization - Name	Address	Phone	Fax

Family or Friend - Name	Relationship to Patient	Phone	Information They May Receive

Family or Friend - Name	Relationship to Patient	Phone	Information They May Receive

Information to be released	Date range from (DD/MM/YYYY)	Date range to (DD/MM/YYYY)	How records should be sent

Records to include, or categories I do NOT want released	This authorization expires on

SECTION C. SENSITIVE INFORMATION AND YOUR RIGHTS

Send written revocations to START Medical Records, 4383 Medical Drive, San Antonio, TX 78229. Phone (210) 593-5700, fax (210) 593-5870.

1. Sensitive categories. My record may include information about sexually transmitted disease, HIV or AIDS, behavioral or mental health services, genetic information, and treatment for alcohol or drug use. Texas Health and Safety Code Chapters 81, 546, and 611 and 42 CFR Part 2 give some of these categories added protection. Signing below releases them along with the rest of my record unless I list exclusions in Section B.

2. Signing is voluntary. START will not refuse treatment, refuse payment, or change my enrollment or eligibility for benefits if I decline to sign this authorization (45 CFR 164.508(b)(4)).

3. Revocation. I may revoke this authorization at any time by written notice to START Medical Records. Revocation does not apply to information already released in reliance on it, or where my insurer has a legal right to contest a claim under my policy. If I leave the expiration date in Section B blank, this authorization ends six months from the date I sign it.

4. Access and redisclosure. I may inspect or obtain a copy of the information to be released (45 CFR 164.524), and START may charge a reasonable cost-based fee for copies. Information released to someone who is not a health care provider or health plan may no longer be protected by federal privacy law and could be redisclosed.

SECTION D. SIGNATURE

Signature of Patient or Legal Representative	Printed Name	Date (DD/MM/YYYY)	Witness
Wet signature, or START-approved electronic signature			

Relationship to Patient (if not signed by the patient)	If signed by a personal representative, describe the legal authority to act for the patient