EMORY
HEALTHCARE

AUTHORIZATION FOR RELEASE OF INFORMATION TO EMORY HEALTHCARE

**PATIENTS: Please fill out this top section only and then sign and date the bottom. Thank you.**

Patient Name: (Print) _____

Address: _____City_____State_____

Date of Birth: _____ Home Phone: _____ Work/Cell Phone:_____

_____
Name of Facility Emory is Requesting Information From

_____
Street Address City, State Zip

**Dr. _____, in the Department of Radiation Oncology at Winship Cancer Institute of Emory University requests the following information:**

| **Information** | **Date** |
|---|---|
| ☐ Consultations | _____ |
| ☐ Office notes | _____ |
| ☐ Discharge summary | _____ |
| ☐ Lab results | _____ |
| ☐ Radiology reports | _____ |
| ☐ Operative reports | _____ |
| ☐ Pathology reports | _____ |

☐ Prior radiation records including prescription, treatment plan, record of tx.

☐ Other (Please specify dates of service):_____

☐ DICOM Treatment plan files (Dose Wash/CT)-for information on transferring DICOM files to our secure FTP site, go to http://radiationoncology.emory.edu/patients/patient-records.html

I. Purpose or need for disclosure: _____

II. I authorize the facility named above to send the medical information required by fax: Y / N

_____ _____
Signature of Patient, Parent, Legal Guardian or State Rep Witness

_____ _____
Date Date

This authorization will expire in sixty (60) days from the date signed unless otherwise specified.