

**BLOOD & CANCER CENTER OF  
EAST TEXAS, P.A.**  
825 Medical Drive  
Tyler, TX 75701  
Telephone: (903) 597-2273 Fax: (903) 597-2466

**Authorization for Release of Medical Records**

Date: \_\_\_\_\_

PATIENT NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH:		
SOCIAL SECURITY #:		

**I hereby authorize Blood and Cancer Center of East Texas, PA to  
release and/or obtain confidential information (medical records)  
to/from:**

NAME OF DOCTOR OR HOSPITAL:		
ADDRESS:		
CITY:	STATE:	ZIP:

**The following information is to be sent and/or obtained  
(check all that apply):**

ALL RECORDS: _____	RADIOLOGY: _____
LAB: _____	EKG/ECG: _____
PATHOLOGY: _____	HOSP RECORDS: _____
RAD TX RECORDS: _____	CHEMO RECORDS: _____
OTHER: _____	

(Please Specify)

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*In keeping with our duty to protect our patient's confidentiality, this facility will not release any medical information without a signed Authorization for Release of Medical Records form. I understand that I may revoke this authorization in writing at any time prior to the information specified above being released. A parent or legal guardian will be required to sign the Authorization form if the patient is a minor or if the patient has been adjudicated incompetent to manage his or her personal affairs, and an attorney ad litem has been appointed for the patient. This authorization expires 180 days from the date signed.*

*Pursuant to state and federal law, you are hereby advised that the information you have authorized for release to/from Blood and Cancer Center of East Texas may include: and/all test results, diagnosis, and/or treatment for HIV (Aids virus), sexually transmitted disease (e.g., Herpes,*

*Chlamydia), psychiatric disorders/mental health, or drug and/or alcohol abuse. By signing the Authorization to Release Medical Records form, you thereby release and hold harmless Blood and Cancer Center of East Texas, PA and its employees from all legal responsibility or liability that may arise from that act that has been authorized above.*

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
(if desired)

Notice of Recipients of Information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42, CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of this information in a criminal investigation and from prosecution of any alcohol or drug abuse client patients.