Karmanos CANCER INSTITUTE | McLaren PROTON THERAPY CENTER

tel (810) 342-3800 • fax (810) 342-3784
kcnflint@mclaren.org

tel (810) 342-3840 • fax (810) 342-4229
protontherapy@mclaren.org

4100 Beecher Rd., Flint, MI 48532
karmanos.org/flintcancer

Authroization to Release Medical Information

This form may be faxed or emailed with attention to the Patient Navigator.

Patient Name: _____ Medical Record Number: _____

Maiden/Other Names: _____

DOB: ____/____/_____ SSN: _____ - _____ - _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____

The purpose of this disclosure: Continuity of Care

I authorize (please initial):	**To release medical information to:**
____ Person, class of persons or health organization: Name of Practice: _____ Address: _____ City: _____ State: ____ Zip: _____ Phone: (____) ____ - _____ Fax: (____) ____ - _____ ____ All medical institutions/offices contacted by Karmanos Cancer Institute at McLaren Flint and McLaren Proton Therapy Center	Karmanos Cancer Institute at McLaren Flint and McLaren Proton Therapy Center
____ Karmanos Cancer Institute at McLaren Flint and McLaren Proton Therapy Center	All medical institutions/offices that contact Karmanos Cancer Institute at McLaren Flint and McLaren Proton Therapy Center

☐ I give consent to release entire medical record for dates of service listed, including all information noted below.

Initials: ____ Date: ____ / ____ / _____

____ I authorize the below specific type of information to be disclosed (please initial):

	Date(s) of service
☐ History and Physical	____ / ____ / _____
☐ Consultation Reports	____ / ____ / _____
☐ Laboratory Results	____ / ____ / _____
☐ Diagnostic Imaging (e.g., X-rays) reports	____ / ____ / _____
☐ Diagnostic Imaging (e.g., X-rays) films	____ / ____ / _____
☐ Other: _____	____ / ____ / _____

____ I authorize the below sensitive information to be disclosed (please initial):

	Date(s) of service
☐ Behavioral and Mental Health Service Information (excluding psychotherapy notes)	____ / ____ / _____
☐ Referrals and treatment for alcohol and substance use disorder	____ / ____ / _____
☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)	____ / ____ / _____

Continue to page 3 for acknowldegements and signatures.

By signing this form, I understand:

1. That I do not need to sign this form to ensure treatment, payment for treatment or enrollment, or eligibility for health benefits.
2. My health information may be shared electronically.
3. The sharing of my health information will follow state and federal laws and regulations.
4. This form does not give my consent to share psychotherapy notes as defined by federal law.
5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after the date it was signed, unless otherwise specified. Upon conclusion of that period, this authorization is automatically revoked and no further disclosure of my information is permitted.
6. I should tell all agencies and people listed on this form when I withdraw my consent.
7. I can have a copy of this form.
8. That unless otherwise indicated or specified here, a request for disclosure or release of my “Entire Medical Record” or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
9. That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.
10. I understand that if I request for Karmanos and McLaren to email me a copy of my medical record, it may not be possible due to mailbox size and/or security restrictions. I also understand that Karmanos and McLaren will apply reasonable safeguards but cannot guarantee the security of my record when sending it to an unsecured personal email account.
11. By signing this form, I confirm that I understand the information and any questions that have been answered about this form.

_____ ____ / ____ / _____

Signature of Patient or Legal Representative Date

_____

If signed by legal representative, state relationship to patient.

_____ ____ / ____ / _____

Signature of Witness Date