TEXAS CENTER *for* PROTON THERAPY

Consent / Authorization for Release of Information

1. I hereby authorize:

Name: The Texas Center for Proton Therapy

1501 W. Royal Lane, Irving, TX 75063

Phone: 469-513-5500 FAX: 469-420-9600

To release the following information from the health record (s) of

Patient's Name: _____ Date of Birth: _____

2. Information to be released: (circle)

Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)

Other: (please specify) _____

3. Information is to be released to:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Purpose of disclosure (circle one):

Treatment **Payment** **Health Care Operations** **Other** (Specify Below)

_____

4. I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.

5. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

6. The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

7. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

**There is a $25.00 fee for the first 20 pages, and $.50 cents per each additional page when applicable. Please allow two weeks notice for releases.*

Signature: _____ Date: _____

Patient or Legal Representative

Witness: _____ Relationship: _____