AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

THE UNIVERSITY OF CHICAGO MEDICINE

The Duchossois Center for Advanced Medicine
5758 S. Maryland Avenue
Chicago, Illinois 60637
Phone: 773-702-8222
Fax: 773-__________ (ATTN-> _________)

RELEASING HEALTH CARE FACILITY: ____

PHONE: ______________________________ FAX: ______________________________

ATTN (CIRCLE ONE): **RADIOLOGY PATHOLOGY HIM/Medical Records**

Date of Birth: ______________________________

I, ______________________, do hereby authorize the Health Care Facility listed above to release my medical record to:

ATTENTION: NEW PATIENT ASSOCIATES
University of Chicago Medicine| Comprehensive Cancer Center| 5758 S. Maryland Avenue|
DCAM Room 1010|Chicago, IL 60637

Please send the following information to the fax number listed above. If you are sending slides or CD's, please use the billing information provided on the fax cover letter.

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Purpose of Disclosure: Second opinion/ treatment options

I understand that I may revoke this consent at any time by giving written notice to: The Medical Records Department of The University of Chicago Medical Center. If no prior notice of revocation is received, this consent will expire automatically 90 days after the date indicated below.

I understand I have the right to inspect and copy information to be disclosed.

I understand that if I refuse to consent to this release of information the following are the consequences (specify, if any):

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______________________________ X______________________________

Date **Patient Signature**

Parent/Guardian Signature: ______________________________

Relationship: ______________________________

Date of Release: ______________________________

PROHIBITION ON REDISCLOSURE

Federal regulations may prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.