



Use this form to request patient records from an outside physician or medical practice.  
Obtain patient's signature prior to sending to physician office.

**PATIENT REQUEST FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	Date of Birth	Social Security Number
Address (Street, City, State, ZIP Code)		Telephone Number
The following individual or organization is authorized to make the disclosure: (name of physician or medical practice) _____		
This information may be disclosed to and used by the following individual or organization: (name and address of 21C physician or practice) _____ _____		
The following information is to be disclosed: (describe the information to be disclosed in a specific and meaningful fashion)  <input type="checkbox"/> Physician Dictation <input type="checkbox"/> Dosimetry Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Diagnostic Films (describe) _____ <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Consultation Reports <input type="checkbox"/> Surgery/Pathology <input type="checkbox"/> Portal Films/Simulation Films <input type="checkbox"/> Other (describe) _____		
<b>Sensitive Information:</b> I understand that the information in my record may include information relating to sexually transmitted diseases, AIDS, or HIV infection. It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.		
Signature of Patient or Authorized Representative		Date
If Signed by Legally Authorized Representative, Relationship to Patient		