CENTRAL ALABAMA RADIATION ONCOLOGY

Patient Name:	Date of Birth:

I hereby authorize **Central Alabama Radiation Oncology** to use, disclose and/or obtain my health information for continuation of medical care.

By providing this Authorization, I understand as follows:

(1) I understand that I will receive a copy of the authorization form after I sign it.
(2) I understand that the health information may be subject to re-disclosure by the recipient of the health information. In the case of re-disclosure, such health information may no longer be protected by HIPAA privacy rules.
(3) I understand that if I refuse to sign this authorization my treatment and/ or payment obligations do not change. While signing this authorization is voluntary, refusal to do so may slow the disclosure of records with any appropriate health or payment institution that requires a signed authorization through internal requirements.
(4) I understand that revocation of this authorization may be done by me at any time in writing by notifying the Compliance Officer at Central Alabama Radiation Oncology, LLC, 4143 Carmichael Road, Montgomery, AL, 36106. Should I do so, I understand this will not have any effect on uses or disclosures prior to the receipt of the revocation.

Medical Records use only:

Specific description of the health information to be used/disclosed/obtained:

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Patient Signature **Date**