

**Piedmont Oncology Specialists II, PLLC
Authorization for Use and/or Release of Information**

Name of Patient _____ **Date of Birth** _____

Name of Covered Entity authorized to release information FROM:

Piedmont Oncology Specialists

OR

Physician's Name _____

Address _____

Phone _____ Fax _____

Name of Covered Entity authorized to release information TO:

Piedmont Oncology Specialists

OR

Physician's Name _____

Address _____

Phone _____ Fax _____

Description of information to be released/used:

- Office Notes _____ Lab/X-rays/Tests _____
 Billing Information _____
 Other Medical Records (Describe in detail the level of information to be released/used)

Permitted use of the described information or reason for the request: _____

This authorization will expire on _____ or within 90 days of signed date below.
I understand I have the right to revoke this authorization at any time by sending a written notification.
I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward.

Patient Signature or Personal Representative **Date**

Description of Personal Representative's Authority (attach necessary documentation)