

**FLORIDA CANCER INSTITUTE  
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Telephone #: \_\_\_\_\_

1. I hereby authorize \_\_\_\_\_ to disclose to:  
\_\_\_\_\_. This information is to  
cover the period of \_\_\_\_\_ and is being disclosed for the purpose  
of health care treatment, payment or health care operations.

2. I hereby authorize Dr. \_\_\_\_\_ and/or his staff to discuss my medical  
condition and treatment plan with \_\_\_\_\_

3. Information to be disclosed:

Complete copy of Medical Record     History & Physical     Physician Progress Notes

Lab Reports     Consultation Reports     Nurses Notes

X-ray Reports     X-ray Films

Other (please specify): \_\_\_\_\_

Redislosure of death records from the facility of: \_\_\_\_\_  
(Patient to initial block when asking for redislosure)

4. I understand that this will include information of superconfidential nature relating to:  
(Check, if applicable, the appropriate block along with initials by the patient)

Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency  
Virus) documentation and/or testing results.

Psychiatric care documentation.

Alcohol and/or drug abuse documentation.

5. I understand this authorization may be revoked in writing at any time, except to the extent that action  
has been taken in reliance on this authorization.

6. The facility, its employees, officers and physicians are hereby released from any legal responsibility or  
liability for disclosure of the above information to the extent indicated and authorized herein.

**SIGNED:** \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal representative and relationship to patient if patient unable to sign

\_\_\_\_\_  
Date

**WITNESS:** \_\_\_\_\_

\_\_\_\_\_  
Date