KERRVILLE CANCER CENTER
Hope and compassion since 1989.

Valerian Chyle, Jr., M.D.
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Printed Full Name: _____ DOB: _____

PHONE: _____ CELL: _____ WORK: _____

Mailing Address: _____

Information is to be released: **FAX** _____ **MAIL** _____ **PICK UP** _____ **OVERNIGHT**_____

From: _____
_____
_____

To: Valerian Chyle, Jr., MD
218 Sidney Baker St.
Kerrville, Texas 78028

Please check type of information to be released:

___All records last 2 years	___All Records last _____years	___CT reports
___Progress Notes	___Pathology	___PET Reports
___ Labs	___Colored Treatment Plans	___Other _____

Purpose of Request:

___Appt. Date_____	___Continuance of Care	___Billing/Claims
___Physician Request	___Other	___ Personal Use

I understand that by signing this authorization: (Please initial all that apply)

___I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary

___I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization

___I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations

___I understand I have the right to receive a copy of this authorization

___I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT

Patient/Legal Rep: _____ **DATE:** _____

Relationship to Patient: _____ **PHOTO ID ATTACHED:** _____

OFFICE USE ONLY: DATE RECEIVED: _____ EMPLOYEE _____