SURINDER VOHRA MD PC

TLC Cancer Clinic

1600 Sixth Ave Suite 101 York PA 17345
Phone 717-845-7373 FAX 866-685-8271

Office use only
Received:
Date: _____ Initials: _____

Processed by: _____

Authorization for Disclosure of Protected Health Information

Instructions: *Any incomplete section invalidates this form and the request cannot be processed*

Patient Name (First, Middle, Last)			Patient DOB (Month, DD, YYYY)
Mailing Address of Patient–Street			
City	State	ZIP Code	Phone

Release Information From *(who has your records)*

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Fax: _____

Release Information To *(who needs your records)*

Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Fax: _____

Information to be Released (include dates of service _____)

□ Office Notes □ Radiation Therapy Notes □ Pathology □ Billing records
□ Lab Reports □ Infusion/Treatment record □ Radiology Reports □ Entire Medical record
□ Other (specify content & dates): _____

_____

Information Needed By (Date) :_____

Purpose of Release

☐ Treatment / Continued Care ☐ Disability Determination ☐ Insurance Purposes
☐ Personal Use ☐ Litigation ☐ Other (please explain)_____

_____

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it. I understand that Surinder Vohra MD PC may not condition my treatment, payment, enrollment or eligibility for benefits on my signing this authorization. I understand a photocopy or fax of this form is the same as the original.

I understand the expiration date of this authorization is **1 year** from the date of signing unless I indicate an earlier date or event here_____.

Patient or Legal Representative Signature	**Date Signed (Month, DD, YYYY)**
Printed Name of Patient or Legal Representative	