KERRVILLE CANCER CENTER
Hope and compassion since 1989.

Valerian Chyle, Jr., M.D.
Board Certified Radiation Oncologist
American Board of Radiology
218 Sidney Baker
Kerrville, Texas 78028
(830) 257-2070

AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

Printed Name:_____DOB:_____

Phone: _____ Cell: _____

Mailing Address: _____

I understand that by signing this authorization: <u>PLEASE INITIAL ALL</u>

_____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 my 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:_____

OFFICE USE ONLY: ***Do not fill out past this point***

<u>Information is to be released</u> FAX _____ MAIL _____ PICK UP ____OVERNIGHT_____

<u>From:</u> _____
_____
_____

<u>To:</u> Valerian Chyle, Jr. MD
218 Sidney Baker North St.
Kerrville, Tx 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
___PSA Labs	___Colored Treatment Plans	___Other _____

Purpose of Request:

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