FLORIDA CANCER AFFILIATES
NORTH FLORIDA

Authorization for Release of Medical Information

1. Patient Information

Name- Last, First, M.I.		
Street Address		
City	*State*	*Zip Code*
Birth Date	*Phone Number*	

2. Information to be Disclosed (Please check only one box)

☐ Comprehensive overview of entire chart (contains all Visit Notes, BM/BX Notes, Pathology, Treatment Notes, X-Ray, EKG, and lab reports.

☐ Records pertaining to: _____
(Specific Medical Information, reports, etc. and/or dates of svc.

☐ AIDS or AIDS related illness, and/or HIV test results

☐ Alcohol and/or Drug Abuse Treatment

☐ Psychiatric consults and mental illness, developmental abilities

☐ Sexually Transmitted Disease

☐ Other (describe): _____

3. Disclosed By:

Name		
Street Address		
City	*State*	*Zip Code*

4. Disclosed To:

Name		
Street Address		
City	*State*	*Zip Code*

5. Purpose or need for disclosure. (Please check all applicable categories)

☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation

☐ Application for insurance ☐ Vocational rehabilitation ☐ Patient use

☐ Disability determination ☐ Other: _____

6. This authorization will remain in effect until the above disclosure(s) have been completed unless you specify that this authorization with be effective for an additional tire period. (To specify an additional time period, please check the box below. NOTE that if you specify an additional time period, this authorization will apply to your medical information generated during the additional time period.)

☐ Other specific expiration date: _____
mm/dd/yyyy

7. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Florida Cancer Affiliates will will not be affected if I refuse to sign this authorization.

8. I understand that I may revoke this authorization at any time by notifying Florida Cancer Affiliates in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization.

9. I understand that my health information may be re-disclosed by the persons or organizations receiving my health information from Florida Cancer Affiliates, and that it may no longer be protected by federal or state privacy laws.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. I understand that there may be a charge for copies.

Signature of Patient:_____ **Date:**_____

If signed by person other than patient, state relationship and authority to do so.

Relationship: _____ **Date:** _____

Patient is: ☐ **Minor** ☐ **Incompetent/Incapacitate** ☐ **Deceased**

Legal Auth: ☐ **Legal Guardian** **Parent of Minor** ☐ **Spouse of Deceased**

☐ **Personal Representative of Deceased** ☐ **Health Care Agent** _____

☐ **Other** _____

To be completed by Ocala Oncology Personnel:

Completed by (initials): _____

Date: _____

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NORTH FLORIDA

User Electronic Mail Authorization Form (Optional)

Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record; we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand that you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____
Patient Name (First Name, Middle Initial, Last Name)

_____
Email Address of Patient/Authorized User

_____
Patient's Date of Birth

_____
Physician's Name

Authorized User is:

☐ Patient

☐ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Medical Record Number

_____
Patient's Signature

_____
Date

_____
Signature of Practice Staff
(Confirming User's identity and authority)

_____
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for the patient.