CANCER CENTER AT GAITHERSBURG

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

I understand that I have the right to inspect and receive a copy of the information to be disclosed and I may revoke this authorization at any time in writing, except to the extent that action has been taken based on this authorization.

I understand that I may specify a date for the expiration of this Authorization, but that it shall expire by law, without my express revocation, one year from the date written below, unless the patient is a resident of a nursing home. I direct that this authorization expire on _____, 20_____.

I understand that it may be necessary to fax some information to another physician if required in my mode of treatment.

_____ _____ _____
Patient Signature Date of Birth Date

If the patient is not able to provide consent to the release of information:

State basis for authority to give consent on patient's behalf:
_____Medical care power of attorney, guardianship, court order, or letters of administration (Attach Copy)
_____Relative or person authorized by law (explain relationship or legal authority)
_____

_____
Signature of person authorized to give consent

_____ _____ _____ _____
Address of person authorized to give consent City State Zip

_____ _____
Signature of Patient Date

NOTICE
(To accompany release of alcohol and drug abuse)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42. C.F.R. Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.