

AUTHORIZATION FOR RELEASE OF INFORMATION TO HIGHLANDS ONCOLOGY

1.	I,, hereby authorize:		
	Name/Facility:		
	Complete Address:		
	Phone:Fax:		
2.	To Release to: Highlands Oncology Group Dr.:		
	3232 North, North Hills Blvd. OR Favetteville, AR 72703	808 South 52 nd Street Rogers, AR 727	
	Phone: (479)587-1700	Phone: (479)936-9900	
	Fax: (479) 587-1366	Fax: (479) 936-9944	
	OR		
	Highlands Oncology Rad		
	60 E. Monte Painte		
	Fayetteville, AR 7	2703	
3.	Information of:		
	Patient Name:	Medical Record #:	_
	D.O.B. OR Social Security #:	Phone Number:	_
4.	Information is to be limited to the following Treat	ment Dates (if applicable):	
5.	Information requested to be released:		
	Records from:To:		
	Office Notes Only:		
	All Records:		
	Other? (explain):		
,	Durpose of rologies is at the required of the modifier	1	
6.	Purpose of release is at the request of the patier Insurance Company:	IT OF:	
	A A a di a al Carra		
	Other? (explain):		
7.	This authorization will expire 90 days from the da different time period. Expiration Date: authorization at any time by giving written notic apply to records already released in reliance up signed authorization shall constitute a valid authorization.	I understand that I may revoke this e. A revocation of this authorization will not on the authorization. A photocopy of this	

TURN PAGE OVER FOR COMPLETION



- 8. I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by federal privacy laws.
- 9. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on your signing this authorization.

Signature of Patient or Legal Representative:		
If Legal Representative, authority of Legal Representative:		
Date Signed:		