THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Authorization for Disclosure of Health Information

Patient ACCT# DOB FC SEX Location Print Date MDA #

Diagnostic Imaging

Mail Completed Requests To:
Image Library
M. D. Anderson Cancer Center
1515 Holcombe Blvd. - Unit 57
Houston, TX 77030-4009
Telephone: 713-792-6210
Fax: 713-563-5066

Office Use Only

Originating Location: ☐ ROI ☐ DI ☐ Path ☐ Rad Onc ☐ MCC
Pick Up Location: ☐ ACB ROI ☐ Main Campus ROI

☐ *Copy to the Patient*

(1) I hereby authorize M.D. Anderson Cancer Center to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____
Telephone No. _____ Patient MR#: _____
Covering the period(s) of healthcare: From *(Date)* _____ To *(Date)* _____

(2) Information to be disclosed: *Reports are always included with Diagnostic Images and Pathology Slides & Blocks*

Diagnostic Imaging
☐ Original Images (Film)

☐ Copy Images
( ) Film
( ) CD-ROM

☐ Other: _____

I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing. M.D. Anderson, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(3) This information is to be disclosed to: _____
Address: _____
For the purpose of _____
_____

(4) I understand that this authorization may be revoked in writing at any time, *(please see the M. D. Anderson Notice of Privacy Practices for specific details)* except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
(1 year from signed date)

(5) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization.

(6) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: _____ *(Patient)* *(Date)*

_____ *or (Personal Representative) (Relationship to Patient)* *(Date)*

NOTICE: Slides; Blocks; and Original X-rays - These materials are important to continuing care and constitute an indispensable part of a medical record, and these materials should be brought back for any future hospital or clinic visits.

FOR OFFICE USE ONLY

Rep ID No.: _____ Rep Initials: _____ Date Completed: _____ No. of Pages/Items: _____

Personal Representative Verified: (Rep Initials:) _____

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