



Release of Medical Information

PATIENT LABEL

Release of Medical Information

I hereby authorize the Capital Regional Cancer Center to **release to** my referring physician and/or family physician and any third party (such as an insurance company or government agency, e.g. Blue Cross or Medicare) any medical information and records concerning my treatment when requested for its use in connection with making or determining claim for payment for such treatment and/or diagnosis.

Date: _____ Signature: _____

Assignment of Benefits

I hereby agree to assign payment from my insurance company for claims sent by Capital Regional Cancer Center for medical treatment rendered to me. If payment is mailed to me for claims sent by Capital Regional Cancer Center on my behalf, I will forward payment immediately. I also understand that if I have Medicare coverage, I will be responsible for payment of the 20% that Medicare does not cover if I have no secondary insurance. I agree that should the amount of the insurance benefits be insufficient to cover my expenses, that I will be responsible for payment of the difference. I understand that Capital Regional Cancer Center shall reserve the right to charge 18% per year on the unpaid balance each month statements are mailed and that statements are payable when received unless prior arrangements have been made with Capital Regional Cancer Center.

Date: _____ Signature: _____

Authorization for use or Disclosure of information for purposes other than treatment Payment or healthcare operation

I hereby authorize Capital Regional Cancer Center to use and /or disclose protected health information to :

Name: _____ Relationship _____

Name: _____ Relationship _____

The information to be used or disclosed is: _____

This protected health information is being used for the following purpose: _____

The authorization shall be in force and effect until (specify date) _____ I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the Facility's address.

Date: _____ Signature: _____