GABRAIL CANCER CENTER

4875 Higbee Ave NW - Canton, Ohio 44718
Phone (330) 492-3345
Fax (330) 491-9758

MEDICAL RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM/TO:

DR._____

ADDRESS_____

CITY_____STATE_____ZIP_____

_____ _____
PATIENT NAME PATIENT SIGNATURE

_____ _____
DATE OF BIRTH SOC SEC #

_____ _____
ADDRESS CITY/STATE/ZIP

_____ _____
DATE WITNESS

*This authorization shall expire 1 year from today's date except as indicated below.
*I may revoke the authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on any previous requests before the revocation date.
*NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.