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**Medical Records Release/Request**

(Check one)

**Release**  Releasing information from us to you or your provider

**Request**  Requesting information from another provider to us

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SS# \_\_\_\_\_

I authorize the Charleston Cancer Center to release/request (circle one) the following:

Information to release/requested: \_\_\_\_\_

\_\_\_\_\_

From (name, address, phone, fax):

\_\_\_\_\_

Reason for request: \_\_\_\_\_

Please send information to (name, address, phone, fax):

\_\_\_\_\_

- I understand that this authorization shall be valid through \_\_\_\_\_ (date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_