REGIONAL CANCER CARE ASSOCIATES LLC
89 Sparta Avenue, Suite 130, Sparta, NJ 07871
Phone 973-726-0005 Fax 844-655-1325

Authorization for Use and Disclosure of Health Information
RELEASE OF MEDICAL RECORDS

Patient Name:_____ **DOB**_____

By signing this form I hereby authorize:

_____

(Name & Address of Person/Organization in possession of my health information)

To disclose the health information described below to:
Bohdan E. Halibey, MD, May Abdo-Matkiwsky, DO and Jumana Chatiwala, MD
Address: As Above. Fax: 973-726-4668. Email: Check all that apply:

- ☐ **All Health Information**
- ☐ **Health Information for the date(s)**_____
- ☐ **Health Information for the following treatment/condition:**

  _____
- ☐ **Other specific description:** _____

Reason for this Authorization:

- ☐ **Moving** ___ **I will not return to the area.** ___ **I will be returning to the area.**
- ☐ **Other (specify)**_____

This Authorization expires on _____
(date or event, can state "none")

I understand that I may refuse to sign this Authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an Authorization if to do so would be prohibited by federal or state law. I understand an Authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an Authorization those services may be denied.

I may revoke this Authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it certified mail, return receipt requested, to the Practice Manager at the health care provider listed above.

_____ _____
Patient/Legally Authorized Representative **Date**
Printed Name_____
Relationship to Patient_____