AVAM
CANCER AND BLOOD SPECIALISTS, LLC
3543 West Braddock Road, Suite 400E, Alexandria, VA 22302
Phone:703-574-0708 Fax:703-574-0709

Authorization to Disclose Protected Health Information

I authorize AVAM Cancer and Blood Specialists, LLC to obtain the protected health information of:
Patient Name: _____ DOB: _____
Address: _____ City/State/ZIP: _____Patient ID: _____
Phone: _____

From:
Name of Person or Facility: _____
Address: _____ City/State/ZIP: _____
Phone: _____ FAX: _____
Email: _____

From:
Name of Person or Facility: _____
Address: _____ City/State/ZIP: _____
Phone: _____ FAX: _____
Email: _____

Dates of service to be disclosed: _____

Types of documents/information to be disclosed:

_____ Clinic notes _____ History _____ Operative/ procedure noted _____ Lab report
_____ All imaging _____ Billing _____ Entire record _____ Pathology reports _____ (list)

Purpose of this request:_____

I understand that I am giving my permission to AVAM Cancer and Blood Specialists, LLC for disclosure of confidential health records. I understand that AVAM Cancer and Blood Specialists, LLC may not condition treatment or payment on my willingness to sign this Authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this Authorization. I also understand that I have the right to revoke this Authorization at any time by sending a written request to **AVAM Cancer and Blood Specialists, LLC**, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this Authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this Authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Unless otherwise revoked, this authorization will expire in 90 days from the date below ***or*** on the following date, event, or condition. _____

I understand that I will receive a copy of this signed Authorization form.

I have read and understand the information in this Authorization form.

Signature of Patient or Authorized Representative:	
Printed Name:	
Date:	**Time:**
Relationship of Authorized Representative (if applicable):	