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HIPPA COMPLIANT REQUEST FOR MEDICAL RECORDS

This document authorizes you to disclose to Greater Washington Oncology Associates

the following health information concerning ______________________________

whose date of birth is _______________________ and whose social security number

is _________________________ for the purpose of continuing medical management

of the patient's health issues.

This authorization applies to the following records:

- ☐ All Medical records including, but not limited to, inpatient, outpatient and emergency room treatment, all clinical records, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. This also includes all CT scans, mammograms, MRI's and any other radiological reports that may be available and laboratory results. This also includes any pathology reports available.
- ☐ Laboratory results.
- ☐ Radiology results such as CT scans, MRI's, mammograms, bone scans and pathology.
- ☐ Office progress notes and any handwritten physician notes.

This authorization does not apply to psychiatric, psychotherapy or psychological notes or records.

By signing below, I further acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This authorization expires two years from the date signed below.

______________________________________ ____________________

Signature of Patient Date