Affiliated Oncologists

Gynecologic Cancer Institute of Chicago
A Division of Affiliated Oncologists

Date: _____ From: _____

To: _____ Fax: _____

Authorization to Release Health Information/Records Request to Affiliated Oncologists

Patient, _____, (date of birth) _____ has an appointment with _____. In order to make the consultation as meaningful as possible, please provide the following records, as marked, to our office within, at least, 3 business days prior to the appointment.

__Consult/H&P
__OP Report/Procedure Report
__Follow-up Notes
__Progress Notes
__Discharge Summary
__Weekly CBC Reports
__PSA Scores
__All Labs
__Tumor Markers
__Pathology Reports
__Pathology Slides
__EKG
__All CT Scans/X-rays/Ultrasounds
__Mammograms
__Radiotherapy Treatment Records
__Entire Chart
__Chemotherapy Flow Sheet
__Other _____

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facilities receiving it and then would no longer be protected by federal policy regulations.

Please fax back to _____ with the attention of _____

Patient Name: _____

Patient Signature: _____ Date: _____

***** CONFIDENTIALITY NOTICE *****

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