ZANGMEISTER CANCER CENTER

The Choice for Oncology & Hematology

3100 Plaza Properties Blvd., Columbus, OH 43219
Gynecologic Oncology: Phone: 614.383.6110 Fax: 614.383.6483
Medical Oncology: Phone: 614.383.6114 Fax: 614.383.6492

Today's Date	
Patient's Name	
Address	
Phone	
Date of Birth	

AUTHORIZATION TO RELEASE INFORMATION TO THE ZANGMEISTER CANCER CENTER

I, _____, authorize and request _____
(patient) (hospital and/or physician)

to furnish to Dr. _____, 3100 Plaza Properties Blvd., Columbus, OH 43219,

(614) 383-_____, (phone), (614) 383-_____ (fax), all information concerning my case history and

treatment, examinations and hospitalizations, including copies of hospital and medical records during the

period from _____ to _____.

Requested information should include:

- ☐ History and Physical Notes
- ☐ Lab Reports
- ☐ Consultations
- ☐ Psychological Reports
- ☐ Discharge Summaries
- ☐ Pathology
- ☐ Radiology/Scans/Disc
- ☐ Progress Notes
- ☐ EKG Results
- ☐ Medications

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer in writing at the address indicated below, and that this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. Address: 3100 Plaza Properties Blvd., Columbus, OH 43219
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. However, other state or federal regulations may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

Signed: _____ Date: _____
(patient's signature)

Witnessed: _____ Date: _____