



Chattanooga's Program In Women's Oncology
 Comprehensive Cancer Care for Women
Let us guide you through your storm.

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**AUTHORIZATION FOR USE OR DISCLOSURE OF
 PROTECTED HEALTH INFORMATION**

I Hereby Authorize: _____

To Release Records To: **Stephen DePasquale, M.D.**
Chattanooga's Program In Women's Oncology

THE FOLLOWING RECORDS IN YOUR POSSESSION:

Progress Notes _____ Lab Results _____
 Entire Record _____ Other (specify) _____

FOR THE DATES OF TREATMENT: _____

This information is for the purpose of :
 Referral To/From Another: Physician _____ Patient Request _____

** I understand that this release is effective for six months from the date below and that it may be withdrawn from me in writing at any time. **

** Potential for Re-Disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulation. **

PATIENT NAME: _____

DATE OF BIRTH: _____ SS#: _____

 PATIENT SIGNATURE DATE

 WITNESS SIGNATURE DATE