Michiana Hematology Oncology, PC
The Power of Research-Based Medicine & The Art of Compassionate Care
3975 William Richardson Drive, South Bend, IN 46628

Authorization for Release of Protected Health Information

I, the undersigned, authorize Dr. _____ and Michiana Hematology Oncology, P.C. to disclose the following protected health information [check all that apply]:

( ) Physician Correspondence; ( ) Dictation; ( ) Laboratory Reports; ( ) X-ray Reports;
( ) Surgical Pathology; ( ) Nurse Practitioner Notes; ( ) Hospital Notes;
( ) Medications & Messages; ( ) Nurse's Notes; ( ) Demographic Information;
( ) Health Insurance Plan Information; ( ) Other _____

This authorization specifically authorizes Michiana Hematology Oncology, P.C. to disclose records of:

( ) Alcohol and/or Substance Abuse; ( ) Mental Health; ( ) Communicable Disease

Dates to be released: ( ) All; ( ) Treatment date(s) _____ to _____

To the following third party or parties: Hoosier Services Inc.

for the purpose of Life Insurance

This consent is subject to revocation at any time except to the extent that it has already been acted upon. If not previously revoked, this consent will terminate on _____ [60 days].

I also understand that the disclosed information may be further disclosed by the above-named third party or parties and it may no longer be protected by the Final Privacy Rule.

_____ _____
[Patient/Legal Representative Signature] [Date Signed]

_____ _____
[Patient/Legal Representative Printed Name] [Patient Date of Birth]

_____

_____
[Patient/Legal Representative Address]