1653 Mahan Center Blvd., Tallahassee, FL 32308
Tel: (850) 219-8000 • Fax: (850) 219-8003

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, authorize Dr. Amer G. Rassam of Tallahassee Cancer Institute and/or any relevant medical staff to discuss only, my medical condition or billing information with the following person(s) or organization. I do acknowledge that a written authorization is required in order to release any medical records to this/these individuals. I understand that this authorization is voluntary. I also understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release **Tallahassee Cancer Institute, PL** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. I understand that the charge for this service is $1.00 per page for the first 25 pages and $0.25 for each page in excess of 25 pages, in accordance with Florida Administrative Code 64B8-10.003. Please allow two weeks' notice for releases.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_______________________________________ Relationship:_______________________________

_______________________________________ Relationship:_______________________________

Patient's/Guardian's Signature:______________________________________Date:________________

Printed Name of Patient/Guardian:___________________________________ Date:________________