



ARNOLD PALMER PROSTATE CENTER

AT EISENHOWER LUCY CURCI CANCER CENTER

PATIENT HEALTH INFORMATION RELEASE FORM

I HEREBY AUTHORIZE:

NAME OF HOSPITAL, DOCTOR, LABORATORY OR DEPARTMENT

ADDRESS

CITY

STATE

ZIP CODE

TO RELEASE TO:

**John Stevenson, MD
Medical Director
Arnold Palmer Prostate Center
39000 Bob Hope Drive
Rancho Mirage, CA 92270**

RECORDS AND INFORMATION OF:

PATIENT NAME

MEDICAL NUMBER

DATE OF BIRTH

ADDRESS

TELEPHONE

INTENDED USE: CONSULTATION FOR PROSTATE CANCER TREATMENT

Duration: I understand that this authorization is effective immediately and shall be

valid for one year or until the date entered here _____.

Right to Revoke: I understand that I may revoke this authorization in writing at any time.

Reuse: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.



ARNOLD PALMER PROSTATE CENTER

AT EISENHOWER LUCY CURCI CANCER CENTER

PATIENT HEALTH INFORMATION RELEASE FORM

RECORDS TO BE RELEASED

MEDICAL RECORDS INCLUDING LABORATORY REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES. PLEASE INCLUDE ALL OF THE FOLLOWING:

* X-RAYS AND REPORTS

* MRIs AND REPORTS

* CT SCANS AND REPORTS

* NUCLEAR SCANS AND REPORTS

* PATHOLOGY SLIDES AND REPORTS

* OTHER HEALTH INFORMATION (SPECIFY BELOW)

Patient Signature: _____ **Date:** _____

NOTE: Records, slides and radiology will be returned to you on the date of your consultation.

BEFORE SUBMITTING TO YOUR HEALTH CARE PROVIDER, MAKE A COPY OF THE COMPLETE DOCUMENT AND RETAIN IN YOUR FILES.