xCures

Patient Consent for Release of Medical Information

Use this form to allow xCures to share your medical information with another individual or organization.

This form can only be used for one patient. Please submit a separate form for each patient.

Patient who is giving consent

Name	
Date of Birth	
Address	
City	
State	
Zip	
Daytime Phone	

Medical information to be shared

- ☐ Any and all information (including personal, health, demographic and medical records)
- ☐ Only my Cancer Journey (clinical summary)
- ☐ Only limited information (such as for specific treatments, dates of service or billing details)

  Please describe: _____

Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey HIPAA or related state medical privacy laws, you should make sure you are comfortable entrusting your information with that person or organization.

For a Person, print the first and last name, and for an Organization print the most detailed name possible.

Recipient	
Point of Contact (for an Organization)	
Contact Phone #	

Please check the box below describing the person or organization's relationship to you.

- ☐ **Family Member**
- ☐ **Friend**
- ☐ **Healthcare Provider or Doctor**
- ☐ **Other: _____**

Expiration and cancellation

This permission will expire *(check one box only)*:

- ☐ On this date (month, day and year, MM/DD/YYYY) _____
- ☐ When revoked, or upon my death

I understand that I can revoke this authorization at any time by submitting an access revocation form, available online here: Revoke-a-Previous-Authorization-for-Release-of-Patient-Medical-Information.pdf. I understand that cancellation will not apply to information that has already been released under this consent.

Authorization and signature

I allow the use and disclosure of my medical information as described above. This information is being released at my request.

Signature	
Date	

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. If signing this form digitally, you agree that your digital signature bears the same legal authority as your written signature.

Email all completed consent forms to: requests@xcures.com