Medical Records Authorization Form

To: ___________________________________
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You are hereby authorized, and hereby requested, to furnish Long Island Radiation Therapy copies of Medical Records pertaining to:

Patient's Name:____
Date of Birth:____
Social Security #:____

This authorization and request is valid from the date hereof until __________________________ . I understand that the information that I hereby authorize to be disclosed pursuant to this form may be subject to re-disclosure under certain circumstances.

I understand that I may revoke this authorization at any time by giving written notice of revocation to the person or entity first-named above. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

I understand that neither treatment nor payment enrollment nor eligibility for benefits is conditioned upon the execution of this authorization and request.

Dated:______________________________

____________________________________ ____________________________________
Signature of Patient or Personal Representative Name of Patient or Personal Representative

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Description of Personal Representative's Authority