EMORY
PROTON THERAPY CENTER
WINSHIP CANCER INSTITUTE

615 Peachtree St. NE
Atlanta, GA 30308
Phone: 404-251-2690
Fax: 404-251-1245

AUTHORIZATION FOR RELEASE OF INFORMATION TO EMORY HEALTHCARE

Patient Name (Print): _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Department of Radiation Oncology, Winship Cancer Institute, Emory Proton Therapy Center

615 Peachtree St. NE, Atlanta GA 30308. Phone: 404-251-2690 Fax: 404-251-1245

This request and authorization applies to:

- ☐ Consultations
- ☐ Office Visit Notes, History and Physical
- ☐ Names and contacts of Outside Physicians
- ☐ Discharge Summary
- ☐ Lab Results
- ☐ Radiology Reports (DICOM-compliant CDs ALSO REQUIRED)
- ☐ Operative Reports
- ☐ Pathology Reports (including pathology slides and cell blocks)
- ☐ Pathology Reports (including pathology slides and cell blocks)
  - Please mail to: *1364 Clifton Rd. NE Atlanta, GA 30322— Room G-180*
- ☐ Prior Radiation Records including prescription, record of treatment checks, treatment summary
- ☐ Prior Radiation Plan(s), including DICOM export of CT(s), structure set(s) and dose file(s)
- ☐ Other: _____

THIS AUTHORIZATION WILL EXPIRE IN SIXTY (60) DAYS FROM THE DATE SIGNED

_____ _____

WITNESS Date

SIGNATURE OF PATIENT, PARENT OF MINOR, LEGAL GUARDIAN OR STATE REP Date