

**RADIATION ONCOLOGY OF NORTHERN ILLINOIS**  
**The Fox River Cancer Center**  
**1200 Starfire Drive, Ottawa, Illinois 61350**  
**Tel: 815-434-9999 Fax: 888-522-8992**

**Authorization for Release of Medical Records**

I hereby authorize: Radiation Oncology of NI, 1200 Starfire Dr., Ottawa, IL 61350

To release information from the medical records  
of: \_\_\_\_\_

Patient  
Name: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social  
Security: \_\_\_\_\_

Records specifically requested:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I understand that:**

- Information disclosed could be re-disclosed by the person or agency who receives it. If this happens, the information may no longer be protected by state or federal law, including federal privacy regulations.
- My refusal to authorize disclosure of this information will prevent the disclosure of the information, except as required by law.
- Treatment will not be conditioned upon this authorization.
- I have the right to revoke this authorization. I may do this by communicating a written request to Radiation Oncology of Northern Illinois
- This authorization will automatically expire 1 year from the date signed
- I consent to allow release of only the information listed on this form, and only for the purposes identified above
- My individual rights related to my protected health information, are further explained in the RONI "Notice of Privacy Practices"

\_\_\_\_\_  
\_\_\_\_\_  
Patient's signature or Authorized Representative      Date

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Reason this person is authorized to sign

Date

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Signature of Witness

Date