Medical Oncology
Rajesh Bagai, MD
Rakesh K. Bagai, MD
Andrei Balandin, MD
Pranshu Bansal, MD
Anu Batra, MD
Puneet Bhalla, MD
Elisa Tso Bomgaars, MD
Manisha Chandar, DO
Monique Chang, MD
Chad Cherington, MD
Victor Chiu, MD
Azam Farooqui, MD
James Ewing, MD
Luke Halbur, MD
Tara Iyengar, MD
Sujith R. Kalmadi, MD
Roopesh K. Kantala, MD
Tejinder p. Kaur, MD
Christopher M. Kellogg, M
Jasleen K. Khanuja, MD
Parvinderjit S. Khanuja, MD, FACP
Leslie Klein, MD
Anita Koszyk-Szewcyk, MD
Rajesh N. Kukunoor, MD
John (Ziyang) Liu, MD
Boo Ghee Low, MD
Kalyan Mantripragada, MD
Sumeet K. Mendonca, MD
Michael A. Musci, MD, PhD.
Joseph N. Nabong, MD
Onyemaechi Okolo-Taku, MD
Karen Ortiz Cruz, MD
Anthony Pasquarella, MD
Clayton R. Polowy, MD
Joshua Rifkind, MD
Jason Salganick, MD
Sonia Sandhu, MD
Christine Saraceni, DO
Amikar Sehdev, MD, MPH, FACP
Darshil Shah, MD
Mikhail I. Shtivelband, MD, PhD
Zabita Singh, MD
Rohit Sud, MD

Jennifer Barabosa, DNP, FNP-C
Amber Berleen, FNP-C
Jennifer Bernt, MSN, FNP-C
Amber Cano, NP
Cynthia Carsten, MSN, AGACNP-BC
Alex Dacanay, MSN, FNP-C
Nicole Gin, NP
Kasey Huey, FNP
Scott Lightfoot, PA-C
Jenny Littrell, MSN, ACNP-C
Megan Lorenz, FNP-C
John (Jack) McSweeney, ANP
Ryan Mobley, MSN, NP-C, AOCNP
Jasiya Paika, FNP-C
Cathy Payne, RN, MSN, ACNP-BC
Lindsey Rogers, MSN, FNP-C
Keegan Russell, MSN, FNP-C
Ashley Schohn, MSN, FNP-C
Amy Schorn, RN, MSN, CNP
Bettina Siebeneck, MSN, CNP, AOCNP

Radiation Oncology
Aaron A. Ambrad, MD
Ronik Bhangoo, MD
Eric Gross, MD
Patrick Miller, MD
Marianne Mildenberger, MD
Murali Murty, MD, MPA
Tam Nguyen, MD
David Romney, MD
Obias Schifter, MD, FACR
Alice Tsai, MD
Charles Woo, MD

Gynecological Oncology
Mario Javier Pineda, MD, PhD

Pat Hansen
Administrator

Brian Washburn
Chief Operating Officer

Parvinderjit s. Khanuja, MD, FACP
President

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Ironwood Cancer & Research Centers

Outsmarting Cancer One Patient at a Time™

Authorization to Release Protected Health Information TO Ironwood Cancer and Research Centers

For the purpose of continuing patient care

Patient Name_____ **Date of Birth**_____

Address _____

City, State, Zip Code_____

Daytime Telephone Number _____

I hereby authorize the hospital or medical facility in receipt of this form to disclose the following Protected Health Information pertaining to the above referenced patient to:

Ironwood Cancer and Research Centers

☐ Chandler Office	☐ Gilbert Office	☐ Mesa– Arbor Office	☐ Mesa– Dobson Office
P: 480.821.2838	P: 480.890.7705	P: 480.981.1326	P: 480.981.1326
F: 480.821.9444	F: 480.398.8095	F: 480.981.1445	F: 480.981.1445
☐ Glendale Office	☐ Dobson Office	☐ Phoenix Office	☐ Scottsdale Office
P:623-312-3000	P: 480.969.3637	P: 602.494.6800	P: 480-314-6670
F:623-312-3060	F: 480.969.6568	F: 602.494.6803	F: 480-257-1997

☐ **Please release all pertinent records from the dates of** _____ **to** _____

OR

☐ **Please release the following information:**

***I understand this authorization covers records relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV"), Sexually Transmitted Disease (STD), behavioral, and/or mental health, Alcohol and/or drug abuse treatment, genetic testing, if any records exist.**
Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.
***I understand that ICRC will not condition treatment on whether I sign this Authorization.**
***I understand that at any time I have the right to revoke this authorization to release medical records, except if ICRC has already taken action on this Authorization. I understand that in order to revoke this authorization I must do so in writing, and send my revocation to ICRC. I also understand that the revocation only applies to records that have not been released in response to the Authorization.**
***I understand that, once this information has been disclosed to a third party, that the information may not be protected by Federal Privacy Regulations and may be re-disclosed by the third party or entity that has the received this information. I also understand that Ironwood Cancer and Research Centers will not re-disclose my protected health information without my written consent.**
***I understand that this authorization expires one (1) year from the date of signing unless an earlier date is specified in writing.**

_____
Expiration Date

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient (If not patient)