WEST CANCER CENTER & RESEARCH INSTITUTE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____ **ALT. PHONE** _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE WEST CANCER CENTER TO DISCLOSE MY PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? Can we disclose your information to your: spouse, adult child(ren), sibling, or other person? If yes, please write their name, contact information and relationship to you.

Person/Organization Name _____
Relationship _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

REASON FOR DISCLOSURE:

☐ Treatment/Continuing Medical Care
☐ Personal Use
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All Health Information**	☐ Physician's Orders	☐ Progress Notes	☐ Billing Information
☐ History/Physical Exam	☐ Patient Allergies	☐ Discharge Summary	☐ Radiology Reports
☐ Past/Present Medications	☐ Operative Reports	☐ Diagnostic Test Reports	☐ Imaging Films
☐ Lab Results	☐ Consultation Reports	☐ Pathology Reports	☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol, or Substance Abuse Records (excluding Part 2) _____ HIV/AIDS Test Results/Treatment

Your initial at this location serves as specific consent to disclose the above described protected information. You acknowledge that this information, once disclosed, may lose its protected status and be subject to redisclosure.

YOU HAVE A RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month _____ **Day** _____ **Year** _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **West Cancer Center, [***], ATTN: Privacy Officer**. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosures permitted or required by law or have occurred through my prior authorization, and that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____

Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

Proof of legal authority as representative may be requested in advance of disclosure of records.

SIGNATURE X_____ _____

Signature of Minor Individual DATE

Delivery Method: ☐ Mail ☐ Email ☐ Pickup Date: _____

Format requested: ☐ Paper ☐ Electronic media ☐ CD (Only for Imaging)

Records will automatically be mailed 10 days after pick-up date. (Initial) _____

Rejection of Encryption of Email or Electronic Media :

☐ Unencrypted electronic media requested ☐ Unencrypted Email Requested

If electronic delivery of records is requested, either by electronic media or email, delivery shall be made by a secure encrypted method. If you chose to decline secure delivery, your election to receive the records through an unencrypted method serves as acknowledgment of the risks associated and waiver and release of West Cancer Center, its parent and subsidiary companies, affiliated entities, directors, officers, employees and agents ("Released Parties") against any and all claims, now or in the future, relating to the unsecure delivery of your health record information.

Charges: In accordance with HIPAA, West Cancer Center may charge a reasonable cost-based fee to provide a copy of records requested by You which may include labor for copying the records (but not search and retrieval), supplies for copying on paper or electronic media, postage, and preparation of a summary, if You have agreed to the summary in lieu of the actual record; and in the alternative, if an electronic record was requested and is available, a flat fee of $6.50 including postage and supplies. If the records request was made by someone other than the patient or patient's representative, fees as specified by the state in which the records are located shall apply, if applicable.

Informed of charge for copies (Please initial) _____