HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: _____
Patient Name

_____
Street Address

_____
City, State and Zip Code

_____
Telephone number

Date of Birth: _____ Social Security Number: __XXX-XX-_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with documenting my medical care and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All pertinent documentation and medical records including: history and physical, discharge summary, operative reports, consultation reports, progress notes, pathology reports, and any other pertinent documentation.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), alcohol and drug abuse, psychiatric care or other sensitive information. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of review, determination and consultation of program eligibility with Breast Cancer Foundation of the Ozarks and should be sent to:

Breast Cancer Foundation of the Ozarks
620 W. Republic Rd, Suite 107
Springfield, Missouri 65807

Phone Number: 417-862-3838
Fax Number: 417-862-3830
Email: meagan@bcfo.org

Further, I understand:
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. I understand that this authorization is voluntary but is also a condition of eligibility for Breast Cancer Foundation of the Ozarks program and that without a signed authorization for the release of patient information, I will not be eligible for assistance.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until one year from date of execution at which time this authorization expires.

_____ _____
Patient Signature Date

_____
Printed Name of Patient