AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________

Address: ____

Date of Birth: ____________ **Last 4 of SSN**: ___________

I. Information about the Disclosure

I hereby authorize the disclosure of the Patient's protected health information as described below. This Authorization is voluntary.

Persons authorized to disclose the protected health information: _______________________

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Persons/Organizations authorized to receive and use the protected health information: STAT Patients-Family Services, a Michigan nonprofit corporation.

Description of information to be disclosed: Patient's name, address, diagnosis, treatment, how long Patient has been under the care of the person/organization providing the Patient's protected health information.

The purpose of a disclosure to STAT Patients-Family Servicers is to determine if Patient is eligible for financial assistance through its Msg. Russ Kohler Children's Cancer Endowment Fund.

This Authorization will expire sixty (60) days from the date this Authorization is signed.

II. Information about my Rights

- I may revoke this Authorization at any time prior to its expiration date by sending a written revocation notice to each person/organization I previously authorized to disclose protected health information. The revocation will not have any effect on any actions that the person/organization took before it received the revocation notice.

- I may see and copy the information described on this form if I ask for it.

- I am not required to sign this form to receive health care benefits (enrollment, treatment or payment).

- I understand that STAT Patient's-Family Services is not a covered entity and any information disclosed to its representatives will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules. I understand I have the right to request that STAT Patient's-Family Services not redisclose the information to any other party without my further authorization.

[*Signature of Patient's Representative on next page*]

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Patients Name: ______________________________

III. Signature of Patient's Authorized Representative

Date: ____________________

____
Signature

____
Printed Name

Authority of Representative to sign on behalf of Patient:

___ Parent ___ Legal Guardian ___ Court Order ___ Other _________________