PACIFIC CANCER CARE
5 Harris Court, Building T, Suite 201 Monterey, CA. 93940
Privacy Officer: Valeria M. Wareham
(831) 375-4105

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name & Phone number of Relative or Individual's we're able to disclose Protected Health Information to:

	Name	Relationship	Phone number:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Health information to be used or disclosed (check all boxes that you are requesting):

☐ **Verbal** discussion of any and all of my health information, including but not limited to, my diagnosis, lab reports, tests and evaluation results, treatment health status and prescriptions.

☐ **Printed** copies of any and all of my health information, including but not limited to, my diagnosis, lab reports, tests and evaluation results, treatment health status and prescriptions.

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. Then entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released, unless prohibited by law and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.
- HIPAA permits Pacific Cancer Care to use and provide to third parties de-identified data from your medical record for clinical improvement Processes.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE **DATE**

_____
DESCRIPTION OF REPRESENTATIVE AUTHORITY TO ACT FOR THE PATIENT

This form supersedes any previously signed HIPAA documents.

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among Healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by and order of the court or the Department of Health or by law.

Processed by (Print Name & Dept):_____