

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
(Please complete and keep a copy in patient's medical record)

PATIENT INFORMATION:

Name of Patient/Previous Names

Birth Date/Medical Record Number

Street Address

City, State, Zip Code

AUTHORIZES DISCLOSURE TO:

AUTHORIZES DISCLOSURE BY:

Grant County Cancer Coalition, Inc.
PO Box 105
Lancaster WI 53813

Name of Health Care Provider/Doctor
Street Address _____
City, State, Zip Code _____
FAX No. _____
ATTN: _____

INFORMATION TO BE DISCLOSED:

Verification of current diagnosis related to cancer or treatment related to cancer. The Coalition requires a verbal verification only; no records need to be sent.

PURPOSE FOR DISCLOSURE:

To validate diagnosis to qualify for services through Grant County Cancer Coalition, Inc. A member of the GCCC board will be contacting the doctor's office to verify you have cancer.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or receive a copy of the Health Information to be used or disclosed – I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. Right to withdraw this authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____
or for 90 days from the date signed.

I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____

Date: _____

(If signed by other than patient, state relationship and authority to do so)