HIPAA (Health Insurance Portability and Accountability Act of 1996)
Authorization for Use or Disclosure of Information
For Purposes requested by Boone County Cancer Society

I, _____, hereby authorize the Boone County Cancer Society to:

1. Access my personal medical records from my physician(s) and authorize the Boone County Cancer Society to receive copies of those records.
2. Use the following protected health information and /or
3. Disclose the following protected health information to the Boone County Cancer Society.

This protected health information is being used for the following purposes:

1. Patient's demographic information, required by the Boone County Cancer Society to contact patient and perform evaluation.
2. Gather required documents for billing purposes.

This authorization shall be in force and effect until the event that relates to the patient of the purpose of disclosure of this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Attn" Boone County Cancer Society. I understand that a revocation is not effective to the extent that the Boone County Cancer Society has relied on the use or disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights.
- Refuse to sign this authorization.

I understand that I have a right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under Federal Law, (or State Law to the extent the State Law provides greater access rights).
- Refuse to sign Authorization.

The Boone County Cancer Society will not condition my treatment on whether I provide authorization for the requested use or disclosure, except for the following circumstances:

- When the provision of health care by the Boone County Cancer Society is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

The use or disclosure requested under this Authorization will result in direct or indirect remuneration to the Boone County Cancer Society from a third party. (if applicable)

_____ _____
Signature of Patient Date

_____
Printed Name of Patient