HEARING THE OVARIAN CANCER WHISPER

Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____

I hereby authorize the following health care provider and its employees:

_____("Provider")

Address: _____

to disclose my protected health information to:

H.O.W. (Hearing the Ovarian Cancer Whisper)
PO BOX 3504
Jupiter, FL 33469

for purposes of *(all purposes must be stated and described)***: to request a grant.**

This authorization is for the disclosure of the following information *(check all that apply)***:**

[ ] The patient's name.
[ ] Medical Data/Information related to the patient's medical condition.
[ ] Information related to the patient's need for financial assistance.
[ ] Other: _____

Expiration: This authorization will expire:
[ ] exactly one year from the date of execution
[ ] other *(please specify)*: _____

After the expiration date or event listed above, Provider can no longer disclose the protected health information without first obtaining a new authorization form.

This authorization has been given voluntarily. I understand that unless otherwise permitted by law, Provider will not condition treatment or payment on this authorization. I further understand that I have a right to inspect or copy the information to be disclosed and may refuse to sign this authorization.

I understand that I may revoke this authorization at any time by notifying Provider's office in writing, except that revocation may not be valid if Provider has taken action in reliance on this authorization.

I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I fully understand and accept the terms of this authorization.

_____ _____
Patient or Personal Representative's Signature Date

_____
Printed Name of Patient or Personal Representative