UNITED BREAST CANCER FOUNDATION
EST. 2000

HIPAA Compliant Authorization to Use and Disclose Protected Health Information

Pursuant to 45 C.F.R. § 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility ("Provider")

_____

Address

_____

City, State and Zip Code

RE: UBCF grant program eligibility of:

_____	_____
Patient's Full Name	Period of Care
_____	_____
Address	Patient's Date of Birth
_____	_____
City, State Zip Code	Telephone Number (for questions about this authorization)

1. I hereby authorize the Provider listed above to disclose protected health information ("PHI"), as described below in the "Medical Information Form", to United Breast Cancer Foundation ("UBCF") for the period of care listed above. Any facsimile or photocopy of the authorization shall authorize the release of the PHI requested.

2. This disclosure is limited to information pertaining to diagnosis and treatment of breast cancer, specifically as requested on the attached form (Medical Information Form) from UBCF. The PHI is disclosed for the purpose of determining eligibility for programs administered by UBCF.

3. This authorization shall remain in effect until six (6) months after the effective date of the patient's signature.

4. The recipient of the health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information.

5. I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that the provider listed above has acted in reliance upon it, by sending written notification to the provider.

6. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

7. My refusal to sign this authorization will not affect my ability to receive treatment.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for copies of information or your copies may be mailed along with an invoice.

Signature of Individual	Print Name	Date
Signature of Personal Representative	Print Name	Date

If this authorization is signed by someone other than the patient, please state the representative's relationship to the patient: _____

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Medical Information Form

This form must be filled out by an authorized provider, such as a physician, nurse, social worker, or patient/nurse navigator. The form must be completely filled out for consideration for eligibility.

Form completed by (check one):

__Physician __Nurse __Social Worker __Patient Navigator __Nurse Navigator

Patient Name: _____

Provider: _____

Current Diagnosis: _____

Date Diagnosed: _____ Stage/Grade: _____

Cancer Type

__In Situ __Invasive Ductal Carcinoma __Inflammatory __Recurrent Metastasis

Other_____

Complete all that are applicable:

Lumpectomy Date: _____ Mastectomy Date: _____

Chemotherapy Start Date: _____ Projected/Actual End Date: _____

Radiation Start Date: _____ Projected/Actual End Date: _____

Remission/No Evidence of Disease Date: _____

Provider Signature: _____ Date: _____

Title: _____ Email: _____

Printed Name: _____ Phone: _____

If applicable: Licensing State_____ License Number_____

Additional contact person on care team

Name: _____ Phone: _____

Email: _____

If applicable: Licensing State_____ License Number_____