



**HIPAA Compliant Authorization to Use  
and Disclose Protected Health Information**

**Pursuant to 45 C.F.R. § 164.508**

**DO NOT MAIL OR FAX THIS FORM**

**This form is meant to be submitted as an attachment to an application that is completed online.**

**Faxed or mailed forms will not be considered.**

**TO:** \_\_\_\_\_  
Name of Healthcare Provider/Physician/Facility ("Provider")

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

**RE: UBCF grant program eligibility of (PLEASE WRITE CLEARLY):**

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

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:*

\_\_\_\_\_