Patient Authorization for Release of Protected Health Information

Patient Name: _____

Health Care Provider

I authorize the following health care provider and its employees to disclose the information described below:

Provider Name: _____

Address: _____

Information may be disclosed to:
H.O.W. (Hearing the Ovarian Cancer Whisper, Inc.)
P.O. Box 3504
Jupiter, FL 33469
561-262-6343 / www.howflorida.org

Purpose of Disclosure

The purpose of this disclosure is to support my request for financial assistance or a grant from H.O.W.

Information Authorized for Release

Please check all that apply:

- ☐ Patient name
- ☐ Medical information related to my medical condition
- ☐ Information related to my need for financial assistance
- ☐ Other: _____

Expiration

This authorization will expire:

- ☐ One year from the date I sign this form
- ☐ Other date or event: _____ After this authorization expires, the Provider may not disclose additional protected health information under this authorization.

My Rights

- I am signing this authorization voluntarily and may choose not to sign.
- My treatment or payment for treatment will generally not be affected if I do not sign.
- I may review or request a copy of the information being disclosed.
- I may cancel this authorization at any time by notifying my Provider in writing.
- Once shared with H.O.W., my information may no longer be protected by federal privacy laws.
- By signing below, I acknowledge that I have read/understand this authorization and agree to the disclosure described above.

_____ _____

Patient or Personal Representative Signature | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship to Patient (if applicable)

Please keep a copy of this signed authorization for your records.