



## **\*\*Patient Authorization and Notice of Release of Information**

**Print Patient's Name:** \_\_\_\_\_

**Print Physician Name:** \_\_\_\_\_

**Physician Phone Number:** \_\_\_\_\_

Dear Patient:

Woman to Woman is a Campaign/program sponsored by Pacific Shores Hematology – Oncology Foundation (PSHOF) that provides financial support for women who are challenged with cancer who does not have insurance or is deemed uninsured due to denial by private and public payers or meets certain financial criteria, the Pacific Shores Hematology Oncology (PSHOF) W2W Campaign program may provide financial assistance for drugs, exams and treatment, and clinical research costs.

Additional information about the Woman to Woman Campaign program can be found at [www.pacificshoresfoundation.org](http://www.pacificshoresfoundation.org)

In order for PSHOF to provide the described support, we will need to review, use and disclose your protected health information (PHI). By law, only with your prior written authorization may your healthcare provider, health plan or health insurer disclose your PHI to PSHOF.

As soon as we obtain your prior written authorization, we will begin the grant review process. You are not required to agree to this Authorization. However, failure to provide this Authorization may prevent you from becoming eligible for the financial assistance from the W2W fund.

You will receive a copy of the Authorization you sign. Please review this Authorization carefully. If you have any questions regarding this Authorization, please contact your healthcare provider's office. Contact information is included below.

\*\* Patient must sign last page:

\_\_\_\_\_  
Patient Initial

## **AUTHORIZATION**

### **I. Information to Be Disclosed or Used**

This Authorization permits my healthcare providers, health plans and health insurers who provide services to me to use and disclose to PSHOF, all medical records and financial information with respect to my treatment, which may have bearing on the benefits payable for services or products provided through my health care provider, health plan or insurer under any plan providing benefits or services, including, without limitation, the dollar balance of benefits remaining under any applicable lifetime maximum benefits provisions, or which may have a bearing on my medical condition or compliance with therapy. All of this information may be considered PHI, and may, if relevant, include information about HIV/AIDS and/or other communicable diseases, mental health information, and/or information concerning genetic test results.

### **II. Persons Authorized to Disclose Information**

The PHI identified in Paragraph I may be disclosed by my healthcare provider, health plan, health insurer or others who may hold my PHI.

### **III. Persons to Whom Disclosure May Be Made**

The PHI identified in Paragraph I may be disclosed to and/or used by PSHOF located at 444 West Ocean Blvd., Suite 800, Long Beach, CA 90802 and its Board of Directors and the W2W campaign committee members, and any other related entity.

### **IV. Description of Each Purpose**

My PHI may be used for the purposes of applying for grant for a specified amount, and becoming a recipient for financial support to sustain and continue prescribed medical treatment plan, exams, diagnostic tests and drugs for the treatment of cancer provided by PSHOF.

\_\_\_\_\_  
Patient Initial

\*\* Patient must sign last page:

**V. Expiration Date or Event**

California residents only: This Authorization will be effective, unless revoked by me in writing, until December 31, 2015. All other residents: This Authorization will be effective, unless revoked by me in writing, up to one year from the date of this Authorization.

**VI. Notices**

I understand that once my health information is disclosed pursuant to this Authorization, there is no guarantee under federal law that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my health care provider’s treatment of me.

I understand that this Authorization will remain in effect until it expires as described or I provide a written notice of revocation via mail to PSHOF located at PO Box 1429 Long Beach CA 90801. The revocation will be effective immediately upon my health care provider’s receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider or others.

**VII. Signature**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize the use and/or disclosure of my health information in the manner described. I may cancel this Authorization at any time by calling 800-303-0131.

Print Patient’s Name: \_\_\_\_\_

Patient’s Address: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_