CANCER CARE PARTNERSHIP

MOUNT NITTANY HEALTH

PENNSTATE HERSHEY Cancer Institute

Imprint patient plate here

Authorization to Use or Disclose Protected Health Information

CANCER CARE PARTNERSHIP
State College, PA 16803

I authorize the use or disclosure of my health information as described below.

1. Person or organization authorized to use or disclose the information: _____
2. Person or organization authorized to receive the information: _____
3. Description of information that may be used or disclosed: _____

   Date of service: _____
4. Purpose of the use or disclosure of information:

   ❑ Continuity of care ❑ Insurance ❑ Personal ❑ Legal ❑ Other _____
5. This authorization expires in one year.
6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain other treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization. **(Not required if the disclosure is requested by the patient.)**
8. I understand that I may revoke this authorization in writing at any time. I understand that any information previously released cannot be revoked.

_____ _____
Signature of Patient, Parent or Legal Representative Date

_____ _____
Relationship to Patient Witness

Office Use only: Photo ID obtained _____ Records released on _____
Number of pages _____ Records released by _____

MR-055-CC

Original - Medical Record Yellow - Patient or Representative Revised 9/18/13

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