ROCK COUNTY CANCER COALITION
Caring | Community | Compassion

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____
Name of Patient/Previous Names | Birth Date/Medical Record Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES DISCLOSURE TO:
Rock County Cancer Coalition, Inc
PO Box 2092
Janesville, WI 53547

AUTHORIZES DISCLOSURE BY:

_____
Name of Health Care Provider
Address _____
City, State _____
Zip _____
Attn. _____

INFORMATION TO BE DISCLOSED:
Verification of current diagnosis related to cancer or treatment related to cancer.

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through Rock County Cancer Coalition, Inc.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or receive a copy of the Health Information to be used or disclosed – I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. The consequence of not signing the authorization form would be that information will not be disclosed. Right to withdraw this authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good for 90 days from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____Date:_____
(If signed by other than patient, state relationship and authority to do so)