HIPPA Authorization for Use / Disclosure of Protected Health Information

Physician: ____

Physician's Address:

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Physician's Phone: ____

Patient's Name: (Print clearly) **Patient's Date of Birth:**

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I authorize the use and disclosure to Shirley's Way of protected health information about the Patient as described below:

Information that may be used / disclosed: All protected health information relating to Physician's assessments of:

(a) Whether the Patient is medically eligible for assistance from Shirley's Way
(b) If so, whether his / her needed financial assistance is appropriate. In addition, Physician is authorized to fill out, sign and provide to Shirley's Way forms that Shirley's Way may require, including forms relating to Patient's medical eligibility for financial assistance needed.

Persons authorized to use / disclose the information" The Physician identified above, as well as his / her authorized representatives.

Persons authorized to receive the information: Employees or other authorized representatives of:

Shirley's Way Inc.
PO Box 58098
Louisville KY 40268

info@shirleysway.com
www.ShirleysWay.com

Purpose for which information will be used / disclosed: To Shirley's Way to obtain:

(a) Physician's assessments regarding whether a person is actively receiving cancer treatment or treatment for a life-threatening illness. Or that the patient has received cancer treatments or treatments for a life-threating illness in the past.
(b) Pertinent information relating thereto.
Expiration date: This authorization expires once the patient has received financial assistance from Shirley's Way or final determination is made that the patient does not qualify for financial assistance from Shirley's Way.

Statements required by HIPAA: In accordance with the Health Insurance Portability and accountability act, I acknowledge the following:

(a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;

(b) I understand that if the person / entity that receives the information described above is not a healthcare provider or health plan covered by the federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient Name:

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Patient Signature: **Date:**

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