# HIPAA PRIVACY AUTHORIZATION FORM

## AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, 45 C.F.R. PARTS 160 AND 1647

**1. Authorization**

I authorize_________________________(healthcare provider) to use and disclose the protected health information described in the Application for Financial Assistance to Betty Kearns Center Fund and the BKCF Committee.

**2. Effective Period**

This authorization for release of information covers the period of health care from

A. ☐ ______________ to _________________

***OR***

B. ☐ All past, present and future periods.

**3. Extent of Authorization**

I authorize the release of my complete health record as it pertains to my cancer diagnosis and treatment. Including:

- Date of diagnosis
- Primary cancer type and stage
- Dates of treatment
- Type of Treatment
- Anticipated length of treatment

I authorize the release of financial information as it pertains to my financial hardship due to my cancer diagnosis. Including:

- Employment status
- Income sources for ALL household members
- Total family income/expenses
- Housing status
- Family financial assets (Bank account balances)
- Nature of financial hardship
- Documentation of financial support request (copies of bill statements/invoices

4. This medical financial information may be used by The Betty Kearns Cancer Fund in consideration of the Financial Support Request, being submitted.

5. This authorization shall be in force and effect until ___________(date or event) or until I revoke, in writing.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that my person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining financial assistance through The Betty Kearns Cancer Fund and assistance has already been granted.

7. I understand that my eligibility for financial assistance from The Betty Kearns Cancer Fund is contingent on the signing of this release as applications cannot be processed without legal release of medical and financial information.

8. I understand that The Betty Kearns Cancer Fund will use the information contained within the Application for Financial Assistance only to determine eligibility for assistance and to collect information regarding payee name and address, account number and amount due.

9. I understand that The Betty Kearns Cancer Fund provides temporary financial assistance to individuals who are experiencing distress as a result of cancer. Expenses incurred prior to a cancer diagnosis will not be covered. Funding is limited and based on availability and eligibility.

_______________________________________________ __________________

Signature of patient or personal representative Date

____________________________________________________________________

Printed name of patient or personal representative & relationship to patient