HIPAA Authorization

I, _____, hereby authorize the use or disclosure of information related to my treatment with **[covered entity]** as described and for the purpose set forth in this authorization. My date of birth is _____.

1. **Name(s) of covered entity authorized to provide the health information:**

   [Insert name of covered entity/business associate and address]

2. **Purpose of the request:** At the request of the Patient.

3. **Organization authorized to receive, use and disclose the information:** The Leukemia & Lymphoma Society.

4. **Description of information authorized to be disclosed (*check applicable boxes*):**

	A. **Patient's Contact Information (Name, Address, Phone Number and Email)**
	B. **Patient's Date of Birth**
	C. **Patient's Diagnosis and Date of Diagnosis**
	D. **Patient's Race**

The following paragraphs describe your rights with respect to this Authorization:

- I understand that I have the right to revoke this authorization at any time by notifying in writing the person/organization authorized in Sections 1 and 3 above.
- I understand that the revocation is only effective after it is received, logged by such person/organization and where applicable the providers referred to in paragraph 1 above have been notified. I understand that any use or disclosure made prior to the covered entity's receipt of the revocation will not be affected by the revocation nor will the revocation apply to disclosures made in reliance on this authorization.
- I understand that after this information if disclosed, federal and state law might not protect it and the recipient might redisclose it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I am entitled to receive a copy of this authorization and that a photocopy of this form shall have the same the legal weight as an original.
- I understand that this authorization is voluntary.
- I understand that unless I revoke this authorization sooner, as provided above, this authorization will terminate on the 90th day following the date below.

Signature of Patient: _____ Date: _____

Or Personal Representative's Section:

I, _____, hereby certify that I am the personal representative of _____ and warrant that I have the authority to sign this form on the basis of: _____.

Signature of Personal Representative: _____ Date:_____