HIPAA Authorization

I, _____, hereby voluntarily authorize the use and disclosure of certain health information maintained by my health care provider identified below as described and for the purpose set forth in this Authorization. My date of birth is _____.

1. **Name of health care provider authorized to disclose my health information: [**Insert name and address of health care provider**]**

2. **Purpose of the request:** To receive assistance from the Clinical Trial Support Center of The Leukemia & Lymphoma Society (LLS) as well as other services and resources offered by LLS that relate to my blood cancer diagnosis.

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

4. **Description of health information authorized to be disclosed:** My name, address, telephone number, email address, date of birth, race, medical and treatment history, and information regarding my diagnosis and treatment.

My execution of this Authorization, which may be by electronic signature, means that I understand and agree to the following:

- I understand that I do not need to sign this Authorization in order to receive health care treatment from my health care provider identified above.
- I understand that I may receive a copy of my signed Authorization by contacting my health care provider identified above.
- I understand that the health information subject to this Authorization may be protected by law. I understand that such health information may be re-disclosed by the recipient and no longer protected by the federal health information privacy law known as HIPAA. However, other laws in certain states may prohibit the recipient of my health information from making further disclosure of my information, unless another authorization is obtained from me or unless the further disclosure is specifically permitted or required by law.
- I understand that I have the right to revoke this Authorization in writing at any time by contacting my health care provider at the address listed above. Revoking this Authorization will not have any effect on actions that my health care provider took in reliance on the Authorization before it received notice of my revocation.
- I understand that this Authorization will terminate one (1) year from the date provided below, unless I revoke it sooner.

Signature of Patient: _____ Date: _____

Complete the following section if the individual signing the form is not the patient:
I, _____, hereby certify that I am the personal representative of _____ and represent that I have the authority to sign this form on the basis of: _____.

Signature of Personal Representative: _____ Date:_____