AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

______________________________	______________________________
Name of Patient	Birth Date
______________________________	______________________________
Any previous names	Medical Record Number
______________________________	______________________________
Street Address	City, State, Zip Code

AUTHORIZES DISCLOSURE TO:

G.R.A.C.E., INC
PO BOX 213
RICHLAND CENTER, WI 53581

AUTHORIZES DISCLOSURE BY:

____
Name of Health Care Provider
Street Address______________________________
City, State, Zip______________________________

INFORMATION WE NEED:
Verification of current diagnosis related to cancer or treatment related to cancer.

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through G.R.A.C.E., 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 that 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-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 health plan or eligibility for health care benefits on my decision to sign this authorization. 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, I may contact the facility disclosing my information. I am aware that my withdraw 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 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:
The authorization is good until the following date(s):________________________ or for 90 days from the date signed.

I have had the opportunity to review and understand the content of this authorization form. By signing the authorization, I am confirming that it accurately reflects my wishes.

____ ______________________

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE DATE
(If signed by other than patient, state relationship and authority to do so)