Privacy Authorization Disclosure

(Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

1. **Authorization**

   I authorize *Friends In Pink* to use and disclose my protected health information to all relevant parties, so they may discuss my treatment and financial needs.

2. **Effective Period - All past, present, and future periods.**
3. **This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment.**
4. **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 any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.**
5. **I give permission for my protected health information to be disclosed for purposes of communicating results, and findings to the family members and others listed below:**

Name___________________________________Relationship_________________________________

Name___________________________________Relationship_________________________________

I have received a copy of the Friends In Pink Privacy Authorization Disclosure today.

Applicant/Guardian Signature:__________________________________Date:_________________