Authorization to Release Protected Health Information to a Third Party

Patient Full Name:
Street Address:
City, State, Zip Code:

As the Patient listed above, I voluntarily authorize any physician, nurse, hospital, health care facility, laboratory, pharmacy, health care provider, health care professional, pharmacist, and individual or institutional care giver who has examined, treated or otherwise attended to me, including their medical staff, agents and employees (collectively and hereinafter referenced to as "My Providers"), to use or disclose my "protected health information" as may be covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule") as specified in this Authorization. I understand that "protected health information" may include records disclosed to My Providers by other health care providers and facilities that previously provided treatment to me, if applicable. I also understand that "protected health information" may include information and records protected under Federal Law (such as regarding alcohol and/or drug information) and/or protected under State Law such as regarding mental health, developmental disabilities, privileged or private communications, communicable or infectious diseases, genetic information, alcohol/drug abuse, AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus).

Information to be Used or Disclosed

I authorize My Providers to release my protected health information, including my full and complete Medical Record, health history (including surgeries, radiation therapy, radiosurgery, chemotherapy, clinical trials, and alternative therapies), physical or mental examinations, conditions, diagnoses, prognoses, operative reports, pathologist reports, notes, prescriptions, diagnostic test results, any reports, all scans and images of any kind (x-rays, photographs, MRI, MRA, PET, CT, and any other images), and any and all other health information or records regarding my health or treatment (collectively "My Health Information And Records") to The Brain Tumor Network, Inc., its navigators, affiliates, contractors, agents and employees (hereinafter and collectively "BTN") as specified in this Authorization. I also authorize My Providers to provide discussion and explanation of my protected health information to BTN if clarification is requested by them.

Person(s) Authorized to Make the Use or Disclosure:

I hereby authorize My Providers to make the uses and disclosures specified in this Authorization.

Recipient(s) of Use or Disclosure:

My Health Information and Records may be used by or disclosed to: **The Brain Tumor Network | 816 A1A North, Suite 207 | Ponte Vedra Beach | Florida | 32082** or **Fax 904.273.8707**

Purpose(s) of the Use or Disclosure:

The purpose of the use or disclosure is to provide my Health Information and Records at my request to the BTN as defined above and for uses as described in my Consent for Navigation Services and Release Agreement. I understand that BTN does not assess, diagnose or treat me and does not make decisions about my care;

instead, BTN will seek to provide me with informational resources which I will then discuss with my treatment team. I also understand that BTN navigators are not my nurses, do not have a nurse-patient relationship with me, and do not advise on the selection of health insurance plans or health insurance coverage.

I understand that my Health Information and Records will be stored in the BTN Brain Cloud database to assist with advocacy efforts for brain tumor patients, to review and improve the availability of treatment resources for patients with brain tumors, may be used for research purposes and as otherwise permitted or required by law. To the extent practicable, BTN will only share data that has had identifying information about me removed (de-identified data). However, I understand that if I provide genetic information derived from genomic, molecular, or computational analyses using various technologies, such as genotyping and whole or partial genome sequencing, there is an inherent risk that such information is not fully de-identifiable or could be re-identified. I authorize BTN to store, use and disclose both my de-identified data and my genetic information for the above-listed BTN Brain Cloud database purposes.

Due to the purposes of this disclosure as outlined in this section, this Authorization has no expiration date and will remain in effect unless and until it is revoked.

Right to Revoke:

I understand that I may revoke this Authorization by submitting a written revocation to the following: The Brain Tumor Network, Inc., Attention: Kristie Naines, Executive Director, 816 A1A North Suite 207, Ponte Vedra Beach, Florida 32082. However, such revocation will not be effective with respect to any use or disclosure made by BTN, including any navigator, in reliance on this Authorization before they each received my revocation. Such revocation also will not apply to my de-identified health information or any genetic information already added to the Brain Cloud database maintained by BTN.

At my request, BTN is receiving the Health Information to assist me with identifying informational resources and helping me coordinate my care with my treatment team. I understand that BTN itself is not a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA") and will not provide medical or nursing diagnosis, care or assessment. I understand it is my voluntary decision whether to sign this Authorization; my treatment, payment for health care, enrollment or eligibility for benefits is not conditioned based on whether I sign this Authorization. My ability to receive certain personalized services from BTN may be dependent on my signing this Authorization so that BTN can receive my Health Information to assist me. I also understand that my Health Information and Records used or disclosed based on this Authorization may be subject to re-disclosure by the recipient(s), in which case they might no longer be protected under HIPAA's Privacy Rule.

I understand I have the right to request and receive a copy of this Authorization and to inspect the disclosed information. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

I have read this form, I understand what it says, and any questions of mine have been answered. I am signing this form voluntarily. Verify your full name, then sign and indicate today's date below to signify that you accept and agree to this Authorization Form. ***The patient or legal representative must sign and date this authorization.***

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Signature (required)	**Date:** (mm-dd-yyyy)

Printed Name of Person Signing (**if not patient**) (first, middle last)

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

☐ Legal Spouse ☐ Parent ☐ Legal Guardian ☐ Adult child of patient ☐ Healthcare power of attorney/agent ☐ Other_____