The Vasquez Sarcoma Foundation Patient Relief Fund

HIPAA Authorization for Release of Protected Health Information (PHI)

I, the undersigned applicant, authorize the Vasquez Sarcoma Foundation and its staff to obtain, use, and share my protected health information (PHI) for the purpose of verifying my diagnosis, treatment status, and need for financial assistance.

This authorization applies to the following types of information:

- Medical diagnosis and condition
- Treatment plans and history
- Medical bills and financial statements related to my medical care

I authorize the following individuals and organizations to release my PHI to the Vasquez Sarcoma Foundation

- Name of healthcare provider(s) or hospital(s)_____
- Name of physician(s) _____

_____

I understand that this authorization is voluntary and that I may refuse to sign it. However, if I do not sign, the Vasquez Sarcoma Foundation may be unable to process my application for financial assistance.

I understand that once my PHI is disclosed, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA). The Vasquez Sarcoma Foundation will, however, continue to protect this information in accordance with its confidentiality policy.

This authorization will be valid for one (1) year from the date of my signature, unless I revoke it sooner in writing.

Applicant's Signature: _____

Date: _____