**ARCTIC COLD CAPS HIPAA AUTHORIZATION FORM**

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| **Patient’s Full Name** |  | **Oncologist’s Name** |
|  |  |  |
| **Address** |  | **Patient’s Date of Birth** |
|  |  |  |
| **City, State Zip Code** |  | **Patient’s Telephone Number** |

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. The following person (or class of persons) may receive disclosure of protected health information about me:

*3.*  **ARCTIC COLD CAPS**

**4300 Haddonfield Rd**

**Pennsauken, NJ 08402**

1. The specific information that should be disclosed is (please give dates of service if possible):

**Information pertaining to the cancer diagnosis, chemotherapy orders and treatment plan and ongoing coordination of patient schedules to coincide with Arctic Cold Caps treatment as needed.**

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. My purpose/use of the information is for Arctic Cold Caps Therapy .
4. This authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_, 201\_\_\_, OR upon occurrence of the following event that relates to me or to the purpose of

the intended use or disclosure of information about me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.\***

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature of Individual\*** (The person about whom the information relates) | **Date of Individual’s Signature** | **Date of Birth or  Social Security Number** |

*OR, if applicable –*

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Signature of Guardian\* or Personal Representative of Patient’s Estate** | **Date of Guardian’s/Personal Representative’s Signature** | **Description of Authority to Act  for the Individual** |

***A copy of this completed, signed and dated form must be given to the Individual or other signator.***