

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

**PATIENT INFORMATION:**

\_\_\_\_\_  
Name of Patient/Previous Names

\_\_\_\_\_  
Birth Date/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**AUTHORIZES DISCLOSURE TO:**

GRACE, 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 GRACE, 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 this authorization-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 a 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 or to receive a copy of my withdrawal, 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 that 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:** This 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 this authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
*SIGNATURE OF PATIENT/LEGAL REP*

(If signed by other than patient, state relationship and authority to do so)

\_\_\_\_\_  
*DATE*