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LIVING
BEYOND
BREAST
CANCER

LBBC.ORG

PART 2: HIPAA AUTHORIZATION FORM

(COMPLETE PRIOR TO GIVING TO YOUR HEALTHCARE PROVIDER)

I, _____, give permission to _____ to disclose the following protected health information to:

Living Beyond Breast Cancer

Information to be disclosed (check all that apply):

- Medical Records
- Treatment Records
- Diagnostic Records
- Other: _____

This protected health information is being used or disclosed for verification of breast cancer diagnosis and treatment status, in order to qualify for Living Beyond Breast Cancer's 2008 *Fall Conference Scholarship*.

This authorization expires on: _____.

Living Beyond Breast Cancer (LBBC) is not a health care provider or health plan covered by federal privacy regulation, and the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. If disclosed, information would be disclosed only to entities and individuals associated with the *Scholarship Application*.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment from your physician(s), or educational services or information from Living Beyond Breast Cancer.

You may inspect or copy the protected health information to be used or disclosed under this authorization (back of this page). You may revoke this authorization in writing at any time by sending written notification to Jean Sachs, Chief Executive Officer, Living Beyond Breast Cancer, at 354 West Lancaster Ave, Ste. 224, Haverford, PA 19041. Your notice will not apply to actions taken by LBBC prior to the date we receive your written request to revoke authorization.

Signature of Participant

Date

Printed Name of Participant