PCROWD
Understanding Blood Precursor Conditions

Authorization for Release of Protected Health Information

SECTION 1

o REQUEST COPIES OF MEDICAL RECORD   o REVIEW MEDICAL RECORD

Patient contact Information

First Name

Last Name

Medical Record Number

Gender

Date of Birth

Street

Street 2

City

State

ZIP

Cell Phone Number

Home Phone Number

Work Phone Number

E-mail

SECTION 2

I, ________________________________ do hereby authorize my medical provider to release my protected health information, including copies of my medical record of care received at ________________________________ to Dr. Irene Ghobrial, Principal Investigator at the Center for Prevention of Progression of Blood Cancers (Protocol 14-174), and her collaborators, at the location listed below for the purposes(s) as indicated:

Dana-Farber Cancer Institute
450 Brookline Avenue
HIM 240
Boston, MA 02215
Phone: (617) 582-8664
precursor@partners.org

Purpose (check the appropriate boxes)

- o Medical Care
- o Research
- o Other (Please specify)

Medical Provider Contact Information

Medical Provider First Name

Medical Provider Last Name

Medical Provider Medical Center Name

Street

Street 2

City

State

ZIP

Office Phone Number

Fax Phone Number

Other Phone Number

E-mail

Authorization for Verbal Communication (Please Initial)

___ I also authorize members of my medical provider care team to verbally discuss my protected information with the Dana-Farber Institute Dr. Ghobrial and her team of collaborators.

SECTION 3

Protected health information to be released:

o Clinic visit notes
o Operative reports
o Discharge summary
o Radiology/Imaging
o Pathology reports
o Radiation reports
o Lab reports
o Photographs
o Other (please specify)

SECTION 4

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Office Manager in my Doctor's office. The revocation will be withdrawn except for the following:
    - to the extent that action has been taken in reliance on this authorization.
- If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released per this authorization, if re-disclosed by the giver, is no longer protected by Dana-Farber Cancer Institute.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature ______________________________

Print Name ______________________________

Date (MM/DD/YYYY) ______________________________

When the patient is not competent to give consent, the signature of a legal representative is required.

Signature of Legal Representative ______________________________

Print Name ______________________________

Relationship of representative to patient ______________________________

Date (MM/DD/YYYY) ______________________________