HIPPA FORM

Authorization for Use/Disclosure of Protected Health Information

**Physician Name\***  **Physician Phone Number\***

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First, Last ###-###-####

**Physician Address\***

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Street Address

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Address Line 2

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City State / Province / Region

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Postal / Zip Code Country

**Patient Name\*** **Patient Date of Birth\***

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First, Last MM/DD/YYYY

I authorize the use and disclosure to MARISA’S MISSION, INC. of protected health information about Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician’s assessments of:
(a) whether Patient is medically eligible for a grant from MARISA’S MISSION, INC.; and
(b) if so, whether his/her desired grant is medically appropriate.

In addition, Physician is authorized to fill out, sign and provide to MARISA’S MISSION, INC. certain forms, including without limitation, the Physician Verification Form, that MARISA’S MISSION, INC. may require, including forms relating to Patient’s medical eligibility, the requested grant and medical considerations relating thereto.

Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives. Persons authorized to receive the information: Directors, Officers or Employees or other authorized representatives of:
MARISA’S MISSION, INC. – P. O. BOX 850061, BRAINTREE, MA 02185
\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (fax) www.marisas-mission.org

Purpose for which information will be used/disclosed: To enable MARISA’S MISSION, INC. to obtain:
(a) physician’s assessments regarding whether Patient is medically eligible to receive a grant from MARISA’S MISSION, INC. and, if so, whether the requested grant is medically appropriate; and
(b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient’s grant has been made by MARISA’S MISSION, INC. or a final determination has been made that Patient is either not eligible to receive a grant or not selected for a grant.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:
(a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;
(b) I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

**Patient Name\* Today’s Date \***

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First, Last MM/DD/YYYY

**Patient Representative\* Today’s Date\***

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First, Last MM/DD/YYYY