CREIGHTON UNIVERSITY
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing this form, you permit Creighton University Hereditary Cancer Center to release your study records described below.

A. **Study Participant**. The study participant whose information may be released is:

NAME____
First Name, Middle Name, Last Name, Maiden name

ADDRESS____
Street, City, State

DOB ______________________________________

SOCIAL SECURITY NUMBER ______________________

EMAIL ______________________________________

PHONE NUMBER______________________________Home/Cell **(circle one)**

B. **Records**. I am authorizing release of the following health information (check as applicable):
___Genetic Results ___Pathology Reports ___Procedure report for procedure date: ________
___Entire Record ___Other:

C. **Special Instructions**.
____Please release the following records received by the Hereditary Cancer Center from third parties:
____
____
____Please release : ____

D. Releasing Department. Hereditary Cancer Center, **FAMILY/INDIVIDUAL NUMBER (if known)** ______________________

E. **Recipient**. I give permission to Creighton to release the above records to:

NAME ____

EMAIL ADDRESS: ____
(Records sent via e mail will be encrypted)

ADDRESS ____

F. **Purpose of Release**. The reason I am authorizing release is:____My Request __ Other (describe): ___________________

G. **Expiration**. This authorization expires 6 months from the date or Date/Event: ______________________________

H. **Explanation of Rights**. I, as the participant/participant representative, understand that:

- I have the right to revoke this authorization at any time. I must give my written revocation to: Creighton University, Attn: University Privacy Officer, 2500 California Plaza, Omaha, NE 68178. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
- Creighton may not condition treatment, payment, enrollment in its employee health plan or eligibility for benefits on whether I sign this authorization.
- I have the right to review my health record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health record.
- I am authorizing disclosure of information protected by federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
- A separate authorization is required for the release of psychotherapy notes.

I. **Authorization**. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

______________________________________ ______________________________________
Signature of Study Participant/ Personal Representative Date

______________________________________ ______________________________________
Representative's Relationship to Study Participant (if applicable) Representative's printed name