Dream Big!
Foundation
3421 W Clubview Ct. Mequon, WI 53092 414-801-1658 904-392-9236

Dream Big! Foundation HIPAA Form

Authorization for use/disclosure of Protected Health Information

To: _____
(Physician)

_____
(Physician's Address)

_____
(Physician's phone number)

Re: _____ _____
(Patient – print name legibly) (Patient Date Of Birth)

I authorize the use and disclosure to Dream Big! Foundation of protected health information about the patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessment of patients care / treatment for cancer. In addition, Physician is authorized to fill out, sign and provide Dream Big! Foundation forms that Dream Big! Foundation require, including forms relating to Patient's medical eligibility, the requested wish and medical considerations relating thereto.
Persons authorized to use/disclose the information: The Physician identified above, as well as, his/her authorized respresentatives.
Persons authorized to receive the information : Employees or other authorized representatives of :
Dream Big! Foundation 3421 W Clubview Ct. Mequon, WI 53092 414-801-1658 904-392-9236

Purpose of which information will be used/disclosed: To enable Dream Big! Foundation to obtain:
(a) Physician's assessment regarding whether Patient is medically eligible to have a wish granted by Dream Big! Foundation and , if so, whether the patient has to travel to seek treatment for cancer and
(b) pertinent information relating thereto.

Expiration date: This authorization expires once Patient's wish has been granted by Dream Big! Foundation or a final determination has been made that the Patient is not eligible to receive a wish.

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 a 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 (or representative)Name Patient(or representative) Signature Date