AUTHORIZATION
TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Email Correspondence or Electronic Media

Patient Name	Date of Birth	Verification of Identity

Address:	Home Phone:	Medical Record #:

**Complete the following only if the person authorizing the use or disclosure is not the patient:

Name	Relationship to Patient	Legal Authority
Verification of Identity	Verification of Authority	Witness Signature

By signing this form, I authorize ____
Person, class of persons, or organization

to communicate via: ☐ **Email-** ☐ **Video Teleconference** ☐ **Audio Teleconference**

Other Electronic Media: (Describe) ____
with me and with other health care providers as necessary for my/the patient's medical care and treatment.

**Complete the following only if email correspondence is being authorized:

Patient's Email Address:	Caregiver's Email Address

I understand that the following types of protected health information may be used, disclosed, and retained by the Health care providers as a result of the communications: (Check all that are approved.)

☐ **My personal health information contained in emails and my email address;**

☐ **Video or electronic Diagnostic Images (x-rays, MRIs, CT Scans), Laboratory Test results, Pathology : Reports; and other diagnostic test results.**

☐ **Video recordings (sound and picture) of parts of my body that may include my face;**

I further authorize the disclosure of information related to: (Circle all that are approved.)

☐ **Mental Health** ☐ **Substance Abuse** ☐ **HIV/AIDS**

- I have read and understand the Alert for Electronic Communications and agree that e-mail messages and teleconferences may include protected health information about me the patient, whenever necessary.

- I understand that, by federal law, the Hampton University Proton Therapy Institute (HUPTI) may not use or disclose my health information, except as provided in the HUPTI Notice of Privacy Practices, without my authorization. My signature on this Authorization indi cates that I am giving permission for the uses and disclosures of the protected health information described above.

- I hereby release the HUPTI and its employees from any and all liability that my arise from the release of information as I have directed.

- I understand that I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to the person or institution named above that I am authorizing to disclose my Information. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.

- I understand that I may refuse to sign this Authorization. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

- I understand that once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

This authorization expires automatically upon: ☐ No Expiration Date ☐ Other ______________
(Check One)

Signature of Patient or Representative ________________________ Date ____________________