I, _____, hereby authorize The Cooper Health System to use the health information about me
(Print Name)
that is specified below, and to disclose such health information to

_____
(Identification of recipient, address, telephone number)
for the following purposes:

_____.

If the above purpose(s) includes the use or disclosure of your health information for The Cooper Health System's marketing purposes, or another entity's marketing, The Cooper Health System **will/will not** be paid, either directly or indirectly, for using or disclosing your health information for such marketing purpose(s).

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO THIS AUTHORIZATION

Date(s) of Service _____

☐ Entire Record	☐ Discharge Summary	☐ Consultations
☐ X-Ray & Radiology Reports	☐ Radiology Images	☐ Cardiology Images
☐ Emergency Department Record	☐ Operative Reports	☐ Pathology Report(s)
☐ Drug abuse and/or alcoholism treatment records	☐ Laboratory Results	
☐ History and Physical Consultation(s)	☐ Other (specify) _____	

How would you like to receive the medical records: ☐ CD/DVD ☐ Paper ☐ e-mail _____

This authorization will expire on _____ or when the following event happens: _____.
(Date)

This authorization will automatically expire one year from the date it is given. An authorization for disclosure of psychiatric records will automatically expire 60 days from the date it is given.

I understand that I may revoke this authorization at any time, even if it has not expired, by giving a written notice to the Director of Health Information Management. I understand that my revocation will become effective on the day it is received by The Cooper Health System. I also understand that The Cooper Health System may, under certain circumstances, have a continued right to use or disclose my health information if The Cooper Health System has already used or disclosed the information on the basis of this authorization.

I understand that if I am giving this authorization as a condition of receiving insurance coverage, The Cooper Health System may have access to health information about me if there is a question about a claim I made under the insurance policy. I understand that a full description of other rights that I may have in regard to a revocation of this authorization can be found in The Cooper Health System's Notice of Privacy Practices.

Notice to the Individual Giving This Authorization

Your failure to give this authorization may result in the withholding of treatment or services from you, if the treatment is research-related or if the services were to be provided only for the purpose of creating health information about you.

This Authorization shall operate as a complete release of liability of The Cooper Health System, its trustees, officers, agents and employees for the release of information as specified above.

Once The Cooper Health System discloses information on the basis of this authorization, we have no control over the recipient's use of the information. The person to whom we disclose your information may disclose it to someone else, and The Cooper Health System will no longer be able to protect the information.

Authorization I hereby authorize Cooper University Health Care to disclose the health information as described above. I understand that such disclosure may include information of a more sensitive nature, such as records related to: mental or behavioral health, substance use disorder (drug or alcohol abuse), genetic diseases or testing, sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and reproductive health care services, including, but not limited to, pregnancy, contraception, and termination or loss of pregnancy. I specifically authorize the disclosure of such sensitive health information to the person or institution noted above.

_____ _____
Patient Signature *Date / Time* *Authorized Representative* *Date / Time*

_____ _____
Print Name *Print Name* *Relationship to Patient*

Address: _____ Patient's Date of Birth: _____

_____

PATIENT LABEL

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PHI

Cooper University Health Care

MD Anderson Cancer Center Cooper
Making Cancer History®

RELEASE OF INFORMATION