Date ________________________

AUTHORIZATION TO USE, DISCLOSE, AND EXCHANGE OF HEALTH INFORMATION THROUGH THE ALASKA CANCER CARE ALLIANCE

Patient Name ____ **Date** ______________________________

I authorize the participants in the Alaska Cancer Care Alliance (collectively, "Alliance Participants") to use, and to disclose to, receive from, and/or exchange with other Alliance Participants, all the health information relating to the Patient. Alliance Participants include: Alaska Imaging Associates; Alaska Oncology and Hematology; Anchorage Radiation Therapy Center; Valley Radiation Therapy Center; and such other health care providers that are or become Alliance Participants and that are or will be listed on our website at akcca.net. The Alaska Cancer Care Alliance is a non-profit organization dedicated to easing some of the burden on cancer patients, including centralizing patient registration, sharing test results, and updating patient information for, with, and among Alliance Participants to encourage continuity of care for the Patient, to promote the timeliness and accuracy of information, and to reduce inefficiencies. The Alaska Cancer Care Alliance also may assist the Patient and the Patient's family and friends with locating affordable room and board arrangements when the Patient travels for treatment purposes as well as providing or arranging other similar support measures. Such information also may be used for certain administrative and operational functions of the Alliance. For the purpose(s) of accomplishing the Alliance's goals, as described above, I authorize all of the Patient's health information, including but not limited to, the information listed below, to be used, disclosed, received and/or exchanged:

- Health and Condition
- Seizures/Epilepsy
- Mental health
- Demographic
- Ulcer
- Diagnosis
- Kidney problems
- HIV / AIDS
- Treatment
- Hepatitis/Jaundice at birth
- Substance abuse
- Developmental disabilities
- Laboratory, radiology, and other test results

ACKNOWLEDGMENT:

1. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, payment for services from Alliance Participants, enrollment in a health plan, or eligibility for benefits.
2. I acknowledge and understand that I may revoke this authorization at any time by notifying, in writing, the privacy officer of any Alliance Participant, except to the extent that action already has been taken in reliance upon this authorization.
3. The Alliance is committed to protecting the confidentiality, privacy, and security of the Patient's health information. Generally, Alliance Participants either are health care providers that must comply with federal and state confidentiality, privacy, and security laws and ethical obligations or have signed agreements promising to safeguard the confidentiality, privacy, and security of Patient health information. We are, however, obligated by federal law to state in this authorization that the health information used, disclosed, received, and/or exchanged under this authorization potentially may be subject to redisclosure and no longer be protected by those laws.
4. I will receive a copy of this authorization after I sign it. I may inspect or request copies of information disclosed by this authorization.
5. Unless revoked, this authorization is limited to the following first and last dates:

COMMENCING: ❍ Date of authorization ❍ Other (specify): ________________________________ **ENDING (expiration date or expiration event): (90) days after the treatment relationship ends between the Patient and all Alliance Participants**

SIGNATURE: I HAVE READ AND UNDERSTAND THIS AUTHORIZATION AND HAVE HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED

____ **Date** ______________________
Signature of Patient or Legally Authorized or Personal Representative

____ **Date** ______________________
Grounds for Authority (If signed by Legally Authorized or Personal Representative)