U VERSUS CANCER | US VERSUS CANCER
A HAWAIʻI 501(C)(3) NONPROFIT ORGANIZATION | FEIN - 47-5338638
PO BOX 81615, HAIKU, HI 96708 | TEAM@UVSC.ORG

Authorization for Release of Information

This is a consent for release of information (herein referred to as the "Release of Information") about:

Name of Individual: _____

Date of Birth: _____

I authorize UVSC to obtain the following specific information: (check all that apply)

- ❑ Confirmation of cancer diagnosis and treatment plan (*UVSC does not retain any Personal Health Information)
- ❑ Care Coordination Services
- ❑ Financial References
- ❑ Confirmation of services by providers for the bill(s)/expenses for which I am seeking reimbursement or payment in order to verify the charges incurred and to verify whether the charges are related to my cancer diagnosis.
- ❑ Other: _____

This information may be used for the following purpose(s): (check all that apply)

- ❑ Eligibility verification of UVSC Financial Assistance Program application
- ❑ Verification of Evidence of Financial Need as described in the UVSC Financial Assistance Program application
- ❑ Other:
  _____

This Release of Information will be valid for 12 months from the date of signing this authorization. This Release of Information is not automatically renewable. It expires at the end of the period specified unless revoked in writing sooner.

I understand I have the right to see this information at any time. Any information already released may be used as stated on the consent. By my signature below, I affirm that I have read this release, or it has been read to me, and I understand its content.

Name of Patient, Client or Authorized person (print):

_____

Signature of Patient, Client or Authorized person:

_____

Date:

_____