UCBC
UNIVERSITY CANCER
& BLOOD CENTER

Jeffrey A. Thomas, M.D.
James E. Splichal, M.D.
Petros G. Nikolinakos, M.D.
Cynthia L. Shepherd, M.D.
T. Jane Huang, M.D.
Frederick Flynt, M.D.
Gustavo Westin, MD, M.P.H.
Kuang S. "Aaron" Chang, M.D.

3320 Old Jefferson Rd | Bldg. 700 | Athens, GA 30607
Phone: 706-353-2990 | Fax: 706-353-2992 | universitycancer.com

HIPAA Release Form (Genetic Testing Results)

Authorization to release the protected health information of:

Patient Name			UCBC MRN:
Current Address	City	State	Zip
Social Security Number - -	Phone Number ( )	Date of Birth / /	

This authorization is to obtain protected health information from:

Individual or Healthcare Provider Name			
Address	City	State	Zip
Phone Number ( )	Fax Number ( )	Email Address:	

Delivery Method (Select one):

☐ Mail ☐ Fax ☐ Email to address listed below:

This authorization is to release the protected health information from:

☐ University Cancer & Blood Center 3320 Old Jefferson Road Bldg. 700 Athens, GA. 30607 | Phone / Fax: (706) 353.2990 / (706)353.4357

The purpose of this use or disclosure is to:

☐ Provide the requested information to the healthcare provider listed above.

☐ Other (please specify):

Release the following information:

☐ Genetic Testing Results
Please provide specific test information (date, test name)

This authorization will expire 180 days from the date signed unless otherwise specified below (requests to add a healthcare provider to my record do not expire unless this authorization is revoked):

☐ On the following date: _____

☐ When the following event occurs: _____

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to UCBC. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

Redisclosure: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not protected by Georgia law and may no longer be protected by federal confidentiality law (HIPAA).

Conditioning: I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law, my health information cannot be released or obtained from another provider. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

Patient or Personal Representative Signature*	Date
Print Personal Representative Name *(please attach applicable legal documentation)**	Relationship to Patient

If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of 18.*

For a deceased patient: A copy of the death certificate identifying the surviving spouse is acceptable and allows the surviving spouse to sign this authorization. Other deceased patients: a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of estate.