HAMPTON UNIVERSITY
PROTON THERAPY INSTITUTE

AUTHORIZATION
To Use or Disclose Protected Health Information (PHI)

Patient's Name	Date of Birth	Verification of identity (Driver's License, ID Card, Passport, etc.)	
Patient's Address		Telephone #	Medical Record #

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

Representative's Name	Relationship to Patient	Legal Authority
Representative's Address	Verification of Identity	Verification of Authority

By signing this form, I authorize the following:

Disclosure of the patient's PHI **To & From:**	Disclosure of the patient's PHI **to**:
Person, class of persons, or health organization	Person, class of persons, or health organization **Hampton University Proton Therapy Institute**
All Medical Institutions/Offices Contacted by HUPTI	Address **40 Enterprise Parkway**
Staff For Continuum of Care	**Hampton,VA 23666**
Attn: Phone	Attn: Phone **Dr. Christopher Sinesi** **757.251.6800**

The following protected health information may be disclosed: **All Health Information**

I further authorize the disclosure of the following information which may be included in the protected health information listed above. (check all that are approved)

☐ Mental Health	☐ Substance Abuse	☐ HIV/AIDS	☐ Records created by non-HUPTI

The purpose of the disclosure: **Continuity of Care**

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

I understand that I have the right to revoke this Authorization at any time, if I do so in writing, and address it to the person or institution named above.

I understand that the revocation will not apply to any actions already taken as a result of this authorization.

I understand that I may refuse to sign this Authorization, and 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 expires automatically one (1) year from the date signed, if no other date or event is specified:	Date
This authorization may be used to disclose protected health information of the same type described above, which may be created in the future, until the expiration date.	☐ YES ☐ NO
I have read and understand the information in this authorization form.	
Signature of Patient or Legal Representative	Date

Revised 1.9.14