Pediatric Scholarship Authorization Form for the Use and Disclosure of Protected Health Information (PHI)

The purpose of this form is to grant permission for the University of Texas M. D. Anderson Cancer Center to use my protected health information (“PHI”) for purposes of the Pediatric Scholarship Committee. This information will be kept confidential, and reviewed only by the scholarship committee in order to consider a candidate’s qualification for a scholarship. .

I hereby authorize M. D. Anderson Cancer Center and specifically the Pediatric Scholarship Committee to review and use the following PHI:

- Demographic information (including contact information, age, geographic location);
- Diagnosis, treatment and biographical information;
- Future appointment schedules;

I understand I may revoke this authorization in writing at any time except to the extent M. D. Anderson Cancer Center has already relied on this authorization. I understand that in order to revoke this authorization I must send a written notice stating my intent to revoke this authorization to the Executive Director of Volunteer Services, Unit 1115, M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030.

Unless otherwise revoked, I understand that the specific date or event upon which authorization expires at the end of the 2009-2010 academic year.

I understand that participation in the Pediatric Scholarship Program is voluntary, and I understand that signing this authorization is voluntary, and declining to do so will not affect my health care treatment at M. D. Anderson Cancer Center.

Name/Guardian______________________________Medical Record Number__________

Signature____Date___________________

Please print name(s) of parent (s) and/or legal guardian (s) if applicable

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Signature____

Date:____