THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Authorization for the Use, Access and Disclosure of Protected Health Information (PHI) – Miscellaneous Use

Patient Name: _____
Last **First** **Middle**
MRN (If applicable): _____ **Date of Birth:** _____ **Phone:** _____

I allow The University of Texas MD Anderson Cancer Center and its employees, agents, and representatives (MD Anderson) to share my Protected Health Information (PHI) with:

_"the public"_____

(*insert name(s) of persons to whom PHI will be disclosed; include "the public" if it will potentially be disclosed to the public; include contact information if available*).

I authorize MD Anderson to share the following identifying and health information about me (specify):

First name, diagnosis, personal image (photo)

_____

I understand that my medical record may include information relating to HIV/AIDS status and treatment, substance abuse treatment, genetic testing, mental health treatment and psychotherapy notes, or sexually-transmitted diseases (Sensitive Information). I specifically authorize MD Anderson to disclose these types of Sensitive Information to the person(s) named above, unless otherwise specified here: _____
This information will not be disclosed to the public
_____.

I allow my PHI to be disclosed to the parties listed above for the following purpose(s): _____
For marketing and promotion of blood drives and blood donation campaigns
_____

_____.

I understand this authorization will expire the later of one (1) year from the date the authorization is signed, or upon the following date or event (*specify*): _____.

I understand that if my PHI is shared with someone who is not subject to federal privacy laws, there is no guarantee that the recipient will not re-disclose information that they learn, including information about me and my health status.

I understand that **I may revoke this authorization** in writing at any time, except when MD Anderson has already relied on this authorization and/or the information is in the public domain and no longer under MD Anderson's control. I can revoke this authorization by sending a written request to Privacy Officer, The University of Texas MD Anderson Cancer Center, Institutional Compliance Office, Unit 1640, PO Box 301407, Houston, TX 77230-1407, Phone: 713-745-6636, Fax: 713-563-4324.

This authorization is optional and I do not have to sign it. Refusing to sign will not affect my treatment or payment for services.

Signature of Patient or Legally Authorized Representative: _____

Printed Name: _____ Date: _____

Legally Authorized Representative's Authority:
Check all that apply: ___ Parent ___ Guardian ___Legal Next of Kin (valid upon death of patient only)
___ Other, specify:_____

* Any media requests (including, but not limited to, local, regional or national newspapers or magazines – online or print, television and radio, social media, Internet sites) must be approved and managed by the Communications Office at 713-792-0655.

MD ANDERSON STAFF USE ONLY

EmployeeName/Recipient: Shelly Schultz

Department: Donor Operations, Lab Medicine Telephone#: 713-792-7777

A copy of this form must be given to the signing individual. If the individual is a patient, **a copy must also be sent to HIM, Unit 1200, for inclusion in the medial record.** A copy should also be retained by the issuing department for at least 6 years.