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

T 800-345-6324 F 713-745-5231
myCancerConnection, Unit 704
P.O. Box 301439
Houston, TX 77230-1439

myCancerConnection℠

Authorization for Disclosure of Health Information from Medical Records

(1) I hereby authorize M.D. Anderson Cancer Center to use and disclose the following information from the health records of:

Name:_____ **Date of Birth**: _____

Address:_____ **Telephone**: _____

_____ **Patient Number**: _____

For the purpose of participating in myCancerConnection patient education activities, programs, publications and brochures.

(2) **Information to be disclosed**:

- Demographic information
- Diagnosis
- Treatment plan

I understand that this may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing, if such information is included in my records.

(3) I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will continue for the duration of my participation as an Anderson Network member.

(4) I understand that my treatment at M. D. Anderson will not be affected if I decide not to sign this authorization

(5) I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws.

Signed: _____
(Name) (Date)

_____
or (Personal Representative) (Relationship to Patient) (Date)