13thirty.org

Request and Authorization for Verbal and Written Communication of Protected Health Information to 13thirty Cancer Connect

Patient Name: _____

Patient Address: _____

City/State/Zip: _____

Email Address: _____ Patient Phone: _____

13thirty Cancer Connect may contact me through:

- ☐ Text
- ☐ Leave a voicemail
- ☐ Email

I, (print name here) _____, request and do authorize members of my care team from (name of health care provider or entity to release information) _____ to discuss my or my child's protected health information, including birthdate, diagnosis, and contact information to 13thirty Cancer Connect (1035 7th N St Suite E, Liverpool, NY 13088 - (315) 883-1862) for the purpose of an introduction to its programs and events.

I understand that this authorization is voluntary and I may revoke this consent at any time by providing written notice. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Patient's Signature: _____ Date: _____

Print Name: _____

When a patient is a minor or is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____

Relationship of Representative to Patient: _____

Representative Address: _____

City/State/Zip: _____

Email Address: _____ Representative Phone: _____

Return to staff@13thirty.org.