United Way for Greater Austin – Addressing Cancer Together
Consent / Authorization to Request and Share Information

This form allows United Way for Greater Austin - Addressing Cancer Together (ACT) program staff to receive, request and share my personal health and financial information in order to support my cancer treatment, connection to support services, applications for funding or insurance and payment for services or premiums. Help through ACT is based on available funding and not guaranteed.

PATIENT NAME

First Name _____ Last Name _____

Street Address _____ Phone_____

City _____ State TX Zip _____ County _____
(Bastrop, Hays, Williamson)

I give ACT permission to request, use and share the information shown below marked with an X:

☐	Any and all information to help me receive or pay for services	☐	Income and Assets (checking, savings, money market, income tax returns)
☐	Cancer treatment information and bills	☐	Billing records
☐	Radiology orders, results and bills	☐	Insurance Information
☐	Lab or testing orders, results and bills	☐	Eligibility information including denials
☐	Status of treatment	☐	Social service needs

I authorize the use and disclosure of my information by and between ACT with hospitals, doctors' offices, pathology providers, anesthesiology providers, genetic testing labs, social services providers and insurance providers to support my access to services and financial support related to my cancer treatment.

I understand that I may withdraw or revoke this consent at any time by giving written notice to ACT at the address below. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal privacy protections, including HIPAA (Health Insurance Portability and Accountability ACT).

This authorization expires in 2 years unless revoked earlier, or I specify another time:_____.
I release the organization named in this authorization, and its staff, from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of if requested. A photocopy of this authorization is as valid as the original.

Signature of Patient or Patient Representative Date

Printed Name of Patient or Patient Representative Authority to Represent Patient

Complete form and Return with Referral or submit via mail, fax or portal:
United Way - ACT 5930 Middle Fiskville Rd 5th Fl, Austin TX 78752
FAX 877-512-8834 / Upload to: https://tinyurl.com/ACTdocs