Cancer Response Team
Helping children get supportive cancer care
www.CancerResponseTeam.org

HIPAA Right of Access Form

I,_____, as legal guardian for_____, direct my health care and medical services providers and payers to disclose and release my protected health information below to:

Cancer Response Team, Inc.
20235 N. Cave Creek Road
Suite 104-184
Phoenix, AZ 85024

Health Information to be disclosed only upon the request of the undersigned.

Disclose only that information which the undersigned specifically authorizes.

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee): Please select one or both of the options below:

An electronic record or access through an online portal _____

Hard copy _____

This authorization shall be effective only so long as I am receiving assistance from Cancer Response Team. (NOTE: You may revoke this authorization at any time by notifying your health care providers, preferably in writing.)

_____

Name of the Individual Giving this Authorization

_____ _____

Patient Name Patient Date of Birth

_____

Signature of the Individual Giving this Authority