Lung Cancer Screening Program Authorization for the Use of Protected Health Information

I, the patient, request and authorize ____ *(name of medical office, group, practice, Health Maintenance Organization, health department, community/migrant/rural clinic or other entity)* to release my medical information to the Screening for Life Program and the Lung Cancer Screening Nurse Navigator at Christiana Care Health Service's Helen F. Graham Cancer Center. I understand that the Nurse Navigator will use this information to review my lung cancer screening results with a multidisciplinary team to determine the next course of action regarding lung cancer screening and diagnosis.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

I understand that any Protected Health Information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may not be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a notice of revocation in writing to the Screening for Life Program. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization.

Unless specified or revoked, this authorization will expire one (1) year from the date signed.

I, the patient, have read this form and fully understand the provisions of the release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature: ____

Print name: ______________________________________

Date: _____/_____/_____