HIPAA AUTHORIZATION TO ALLOW PERSONAL HEALTH INFORMATION TO BE SHARED WITH PROVIDERS IN A MULTIDISCIPLINARY TEAM CONFERENCE.

Research Medical Center has a Multidisciplinary Team of health professionals involved in the care of patients with cancer. Each team member brings different skills that are important in managing your care. The team includes health professionals who are involved in diagnosing your cancer, treating your cancer, managing symptoms and side effects, assisting you with your feelings or concerns during your cancer treatment.

To make sure you are receiving the best possible care, the team will meet to review your case and decide on the most appropriate treatments for you. The team will discuss several other patients at the same meeting and there may be some people at the meeting who are not involved in your case. There may also be medical students present at the meeting as part of their education and other healthcare workers that work with the physician groups.

During the Multidisciplinary team meeting, your medical history and test results will be reviewed. Personal or other health information that you have disclosed to any member of the team, including your general practitioner may be shared at the meeting if relevant to your treatment, unless you request otherwise. Physicians and healthcare professionals that participate in this conference agree to keep your health information confidential.

Following the multidisciplinary conference, your physician's office or the Research Medical Center patient navigator will contact you to tell you what course of action the team recommends. You will have the opportunity to ask questions and indicate any preferences you have for your treatment. The final decision about your care plan is made in consultation with you.

Should you have any questions about the multidisciplinary team conference or about how your health information will be utilized, please ask your care provider who is making the request to refer your case to conference.

Research Medical Center must assure we have your consent before we allow your protected health information to be presented to the multidisciplinary team. If you agree to allow your medical information to be shared with the team, please complete the following information on the next page and sign the document. This document will become a permanent part of your Medical Record.

Research MEDICAL CENTER
HCA Midwest HEALTH SYSTEM

Patient name:		**Date of Birth:**	
Address 1:			
Address 2	**City**	**State**	**Zip Code**
Today's Date	**This authorization will expire:** *In One year of signature.*		
Purpose of Disclosure: *Authorize personal health information to be presented to the Multidisciplinary team at conference.*			
Types of Protected Health Information that may be disclosed:	Conversations containing my protected health information including diagnosis(s), written demographic and financial information, procedures		
1. I acknowledge and consent to such that information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **Initial here:**_____ ☐ **Check Here if not applicable:**			
2. I understand that: • I may refuse to sign this authorization and it is strictly voluntary. • My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. • I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. • I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. • I get a copy of this form after I sign it.			
I have read the above and authorize the disclosure of the protected health information as stated during the Multidisciplinary team conference.			
Signature of patient or patient's representative	**Date:**		
Print name of Patient's Representative	**Relationship to patient:**		

Please Return by Fax to: 816-276-3621 OR
Mail to: Research MDC Navigation
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