Attachment O. Medical records release/ HIPAA Authorization form..

Reading level: 10.6

Your medical records provide facts about the diseases you have had. The survey asked about these diseases:

- Cancers
- Parkinson’s disease
- Kidney failure and other severe kidney diseases
- Severe liver diseases
- Lupus
- Aplastic anemia
- TCE-related skin disorders
- Scleroderma
- Infertility
- Endometriosis

We need to use your medical records to confirm that you had one of these diseases. Your medical records cannot be used unless you sign the form that follows. We will keep the records private to the extent allowed by law. Any reports from this survey will only report on the group. Reports will not identify specific people. You have the right to refuse to release your medical records. If you choose not release your medical records, you will not lose any benefits. Please read the form below and fill in the names and addresses (if you know them) of the doctor(s), hospital(s) or other health care provider(s) who treated you for the disease(s) listed above.

We will also be contacting state and federal cancer and tumor registries to get information about any cancer diagnoses. If you had cancer, this form also gives them permission to tell us about your cancer.

MEDICAL RECORDS RELEASE/HIPAA AUTHORIZATION FORM

I, ____________________, request and give permission for the following providers:

State cancer/tumor registries

Doctors

____
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Hospitals

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Other health care providers

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____
____

to disclose the following protected health information to ATSDR's Division of Health Studies or Westat (as an agent for ATSDR's Division of Health Studies):

Medical Records related to diagnosis of the following condition(s):

- Cancers
- Parkinson's disease
- Kidney failure and other severe kidney diseases
- Severe liver diseases
- Lupus
- Aplastic anemia
- TCE-related skin disorders
- Scleroderma
- Infertility
- Endometriosis

This protected health information is being used or disclosed to verify my diagnosis as part of a research study conducted by ATSDR's Division of Health Studies to find out

about the health status of those who resided or worked at U.S. Marine Corps (USMC) Base Camp Lejeune or Camp Pendleton in 1987 or before
This authorization expires on December 31, 2013.

Because ATSDR is not covered by the HIPAA privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. ATSDR and Westat have no plans to disclose this information to any other parties. ATSDR and Westat will take every reasonable precaution to make sure no identifiable information about you or your health care providers is released.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization.

Finally, you may revoke this authorization in writing at any time by sending written notification to ATSDR at [*office address*]. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____
Signature of Participant or Personal Representative

____
Date

____
Printed Name of Participant or Personal Representative

____
Description of Personal Representative’s Authority

Letter for health care provider.

Date

Dear Health Care Provider:

Permission has been granted to the Agency for Toxic Substances and Disease Registry (ATSDR) to obtain medical records for (name of participant). A copy of the medical records release/HIPPA Authorization form is enclosed.

ATSDR is conducting a study of the health of former Marines, their dependents, and civilian workers. (Name of participant) reported (name of condition).

Please indicate whether or not you are able to confirm the diagnosis listed below for (name of participant) born on (DOB).

Condition: ______________________________________

○ **YES**, I can confirm the diagnosis.

○ **NO**, I cannot confirm the diagnosis.

Signature:____

Date:________________________ (mm/dd/yyyy)

Please provide pathology reports, if applicable, and return with this document in the enclosed postage-paid envelope to:

Contractor
Contractor's address

If you have any questions about releasing this information to ATSDR, please contact me at xxx-xxx-xxxx or email me at xxx@cdc.gov. Westat is working with ATSDR on this project. If you have any questions about completing and returning this form, please call xxx at xxx-xxx-xxxx.

Thank you for your time.

Sincerely,

ATSDR Official