



AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Applicant Name: _____ Date: _____ Patient Name (if different :)
_____ Date of Birth: _____ Address:
_____ City/State/Zip: _____ Phone: H) (_____) _____
_____ W) (_____) _____

Facility Name: _____ Facility Phone: (_____) _____ Facility
Address: _____ Facility Fax: (_____) _____ City/State/Zip: _____

This information may be disclosed to and used by the following organization:

Marlene's Kaleidoscope Lupus Foundation

Po Box 14425 Kansas City MO, 64152

Phone 573-738-8648

Health information to be released and Confirmation of SLE (Lupus) diagnosis. The Board of the Lupus Foundation of Southern Arizona may request supporting information from the attending physician, limited to this diagnosis, including consultation reports. Successful applicants will be published in Board proceedings, and names may be released to the public in news releases. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Lupus Foundation of Southern Arizona. I understand that the revocation will not apply to information that has already been released in response to this authorization unless otherwise revoked; this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form for my application to be considered. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 (2015.) I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and federal confidentiality rules may not protect the information. If we have questions about the disclosure of my health information, I can contact the authorized individual or organization making a disclosure. I have read the above foregoing

Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____

Signature of Patient / Parent / Guardian or Authorized Representative /Date (Guardian or Authorized Representative must attach documentation of such status.)

_____ Printed

name of Authorized Representative Relationship / Capacity to patient

_____ Address

and telephone number of authorized representative

ATTESTATION that the APPLICANT or FAMILY MEMBER NAMED ABOVE has been diagnosed with LUPUS:

Health Care Provider Name: _____ Signed:

_____ Date: _____