Connor Moran
Children's Cancer Foundation
Restoring Childhood. Strengthening Families.

2017/2018 Authorization for Release

The mission of Connor Moran Children's Cancer Foundation is to enhance the quality of life, strengthen and stabilize families who are affected by cancer. There is no fee or obligation for our services, however, we do need your consent to advocate on your behalf and that of your family.

I grant my permission/authorization for referral to Connor Moran Children's Cancer Foundation for the purpose of accessing the following service(s): **Please initial each service that Connor Moran can begin to help you with.**

_____Academic Tutoring
_____Advocacy for case management/financial support for family/child(ren)
_____Food/Gas Cards
_____Referral to other agencies for additional patient/family support
_____Other:_____

I understand that this authorization will remain in effect **for one year,** unless I specify an earlier expiration date here. I understand that I may place certain restrictions or withdraw this consent at any time.

About Confidentiality.
Florida law requires that information contained in medical records be held in strict confidence and not be released without written authorization of the client or legal representative (section 395.3025 & 455.214, F.S.). Connor Moran will secure, utilize or disclose only the minimum information needed to deliver our services and fulfill the need that is presented by you. You are entitled to view all information received. Information is treated as confidential and will be held for one year. You are entitled to view all information received. Connor Moran adheres to the FAIR INFORMATION PRACTICES PRINCIPLES set forth by the Health Insurance Portability and Accountability Act (HIPPA).

SIGNATURE
I have read the above, asked questions, received answers concerning areas I did not understand, and willingly give my consent to accept the services of Connor Moran Children's Cancer Foundation.

Name of Parent/Guardian_____(Check if Patient)____Diagnosis_____

Name of Child if Patient_____Diagnosis_____

Address_____City_____Zip_____

Authorizing Signature_____Date_____

Referring Physician_____Contact #_____

Use this space only if client withdraws consent.

Date client revoked consent: _____ ***Signature of Client:*** _____

Fax or mail this completed form to:
401 Old Dixie Hwy., Ste 4221
Jupiter, FL 33477
Phone: 561-741-1144 Fax: 561-741-1144