

HIPAA Authorization to Disclose *Protected Health Information*

Lose to Win Contest

Information to be used and/or disclosed and to whom

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will. I understand that once this information is received by the authorized organization or person, then it may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws.

1. This authorization is valid for 1 year from the date signed.
2. Patient's Name: _____
3. Patient Birth Date: _____
4. Name of organization authorized to make the requested use and/or disclosure:
Little Company of Mary Hospital and Health Care Centers, Inc.
5. Name of organization authorized to receive the information: SouthtownStar.

6. Description of the information to be used and/or disclosed:
 - Weight loss information, including all specific weigh in results as a participant in the Lose To Win contest
 - Age
 - City of residence
 - Reasons for choosing a healthy lifestyle as described on Participant File at initial weigh in
7. Purpose of the requested use and/or disclosure: To provide weight loss information for participation in Lose to Win contest

Right to revoke

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the persons or organization authorized to make the requested use and/or disclosure have taken action in reliance on this authorization.

Ability to participation on execution of this authorization

I understand Little Company of Mary Care Hospital and Health Care Centers condition my participation on my executing this authorization.

Signature

By signing below I acknowledge and affirm the statements in this authorization form.

Signature of Patient

Date

Printed Name of Patient