Columbia University Medical Center

AUTHORIZATION FOR USE AND DISCLOSURE OF LIMITED HEALTH INFORMATION For FUNDRAISING PURPOSES

Columbia University Medical Center (CUMC) relies upon the generosity of our patients to help us remain at the forefront of patient care, research and education. Federal law requires health care providers to obtain your written authorization prior to contacting you about our philanthropic initiatives that support the work of our doctors, and so we now seek your permission to do so. As maintaining patient confidentiality and ensuring your right to privacy remains our highest priority, be assured that your diagnosis or treatment information will not be disclosed without your permission.

We ask that you take a moment to review the authorization and sign below. If you have any questions please call the CUMC Office of Development at (212) 304-7200.

I authorize CUMC to use the **department or program where I am receiving healthcare services and/or the name of my physician** to contact me about information related to my personal health needs and interests, including:

- *New Scientific Advances*
- *Patient Care Programs And Service Enhancements*
- *Community Activities, Presentations, Events, and Health Forums*
- *Opportunities To Support Columbia University Medical Center*

This authorization allows us to personalize our communication to you as we seek to keep you informed about relevant health information and activities at Columbia University Medical Center.

Only your physician, the Office of Development of CUMC or its Business Associates will use this information to discuss or send you information about fundraising opportunities at CUMC.

Failure to sign this authorization will not affect your treatment, payment, or eligibility for benefits in any way.

Information disclosed under this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal or state law.

This authorization is valid until revoked by the patient or their authorized representative. You may revoke this authorization at any time or request to inspect or receive a copy of the protected health information to be used or disclosed by submitting a request in writing to: Office of Development 100 Haven Ave, Suite 29D, N.Y. N.Y. 10032. The revocation will be effective immediately except to the extent that we have already relied on your authorization.

This authorization will expire in 20 years and you have the right to a copy of the signed authorization

NAME OF PATIENT: ____________________________________ **DATE**:____________________

SIGNATURE: ____

ADDRESS: ____

Relationship if someone other than the patient (e.g. parent) _____________________________________

NAME OF PHYSICIAN / DEPARTMENT / PROGRAM ____