The Piggyback Foundation

Carrying Families Through Times of Need Since 2007

Medial Record Release and Authorization

Ohio and Federal law protect the privacy and confidentiality of an individual patient's medical records. In order for The Piggyback Foundation to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be executed and submitted to your health care provider(s).
Please note that you are afforded the following rights with respect to the Release and Authorization:

- You may refuse to sign the Release and Authorizing Form, although you will then be ineligible to receive financial assistance from The Foundation.
- You may revoke the Release and Authorization by submitting a written revocation to the health care provider.
- The revocation will be effective upon receipt by the healthcare provider. • You have the right to receive a copy of this Release and Authorization upon written request.
- You may inspect or obtain copies of all information, which the Foundation receives pursuant to this Release and Authorization.

Name: _____ DOB:_____
Address:_____
City:_____State:_____Zip:_____
Phone Number: _____Last 4 digits SSN:_____
I hereby authorize

_____

(Health Care Provider) to release all pathology reports and medical information regarding my treatment plan to:

The Piggyback Foundation
P.O. Box 436
Norwalk, Ohio 44857

The purpose of this request is to assist The Piggyback Foundation in determining my eligibility for financial assistance.
This Release and Authorization shall expire twelve (12) months form its execution if not revoked prior thereto.

The Foundation will not disseminate or release your medical records to any outside source without first obtaining your prior express consent.

_____

Signature & Date