THE BRAIN TUMOR NETWORK, INC.
AUTHORIZATION FOR
DISCLOSURE OF ALL PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ________________________

Address: __________________________________ Last 4 digits of SSN: _________________

__________________________________ Phone Number:______________________

As the above listed Patient, I voluntarily authorize any physician, nurse, hospital, health care facility, laboratory, pharmacy, health care provider, health care professional, pharmacist, and individual or institutional care giver who has examined, treated or otherwise attended to me, including their medical staff, agents and employees (collectively and hereinafter "My Providers"), to use or disclose my "protected health information" as may be covered under privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule") as specified in this Authorization. I understand that "protected health information" may include records disclosed to My Providers by other health care providers and facilities that previously provided treatment to me, if applicable. I also understand that "protected health information" may include information and records protected under Federal Law (such as regarding alcohol and/or drug information) and/or protected under State Law [such as regarding mental health, developmental disabilities, privileged or private communications, communicable or infectious diseases, genetic information, alcohol/drug abuse, AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus)].

Information to be Used or Disclosed
I authorize My Providers to release my protected health information, including my full and complete Medical Record, health history (including surgeries, radiation therapy, radiosurgery, chemotherapy, clinical trials, and alternative therapies), physical or mental examinations, conditions, diagnoses, prognoses, operative reports, pathologist reports, notes, prescriptions, diagnostic test results, any reports, all scans and images of any kind (x-rays, photographs, MRI, MRA, PET, CT, and any other images), and any and all other health information or records regarding my health or treatment (collectively "My Health Information And Records") to The Brain Tumor Network, Inc., its advisors, and their affiliates, contractors, agents and employees (hereinafter and collectively "BTN") as specified in this Authorization. I also authorize My Providers to provide discussion and explanation of my protected health information to BTN if clarification is requested by them.

Person(s) Authorized to Make the Use or Disclosure:
I hereby authorize My Providers to make the uses and disclosures specified in this Authorization.

Recipient(s) of Use or Disclosure:
My Health Information and Records may be used by or disclosed to: **The Brain Tumor Network, Inc., 816 A1A North, Suite 201**, **Ponte Vedra Beach, Florida 32082 or Fax 904.273.8707**

Purpose(s) of the Use or Disclosure:
The purpose of the use or disclosure is to provide my Health Information and Records at my request and in connection with BTN, including its advisors, providing informational resources to me regarding potential treatment options and clinical trials for my consideration. Due to the purposes of this disclosure, including for research, this Authorization has no expiration date and will remain in effect unless and until it is revoked.

I understand that I may revoke this Authorization by submitting a written revocation to the following: The Brain Tumor Network, Inc., Attention: Kay Verble, Executive Director, 816 A1A North, Suite 201, Ponte Vedra Beach, Florida 32082. However, such revocation will not be effective with respect to any use or disclosure made by BTN, including any advisor, in reliance on this Authorization before they each received my revocation. I understand that my Health Information and Records will be de-identified for use in the creation and maintenance of a research database. If I revoke this Authorization, I understand and agree that the revocation will not apply to my de-identified health information contained in a research database.

I understand that BTN itself is not covered by HIPAA, and my ability to receive services from BTN is dependent on my signing this Authorization. I understand it is my voluntary decision whether to sign this Authorization. I also understand that my Health Information and Records used or disclosed by My Providers based on this Authorization may be subject to redisclosure by the recipient(s), in which case they might no longer be protected under HIPAA's Privacy Rule.

I understand I have the right to request and receive a copy of this Authorization. I understand that I have the right to inspect the disclosed information. A photocopy of this Authorization shall be valid and is to be accepted with the same effect as the original.

I have read this form, I understand what it says, and any questions of mine have been answered. I am signing this form voluntarily. If I am signing on behalf of the Patient, I certify that I am the Patient's authorized representative.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Name of Witness Signature of Witness

If signed on behalf of Patient:

______________________________ ______________________
Name of Patient's Authorized Representative List Relationship to Patient

______________________________ ______________________
Signature of Patient's Authorized Representative Date

______________________________ ______________________
Name of Witness Signature of Witness

[Copy of signed Authorization to be given to the Patient or Patient's Representative]