iTASC Treatment Access for Skin Cancer

Authorization by Patient for Use and Disclosure of Protected Health Information

NOTICE: This Authorization, required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), authorizes us to use and disclose Protected Health Information/Individually Identifiable Health Information (collectively referred to herein as "PHI") as described below.

iTASC is an Internal Revenue Code section 501(c)(3) non-profit organization that operates a software platform that aims to connect underserved skin cancer patients in need of treatment, regardless of their financial resources, with volunteer surgeons who agree to provide the treatment for no charge to the patient. Only an approved referring and accepting provider may use the iTASC platform. iTASC does not provide any treatment or give any medical advice. No information provided through the Service constitutes a medical diagnosis, advice, or treatment. Please consult a healthcare professional for a specific examination and evaluation of your condition.

The undersigned patient (the "Patient") does hereby voluntarily authorize Improving Treatment Access for Skin Cancer, Inc. d/b/a iTASC ("iTASC") to use and disclose my PHI as set forth below.

Type of Information being Released: Detailed description of the PHI information to be used or disclosed: Patient medical information.

Parties Authorized to make the use or disclosure: Name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure of my PHI include: iTASC and/or the American College of Mohs Surgery ("ACMS") and each of their respective directors, trustees, officers, employees, contractors, volunteers, fundraisers, grant writers, grant recipients, education programs, social media, fund raising activities and recipients and each of their respective agents.

Recipient of the information: Name or other identification of the person(s), or class of persons, to whom iTASC may make the requested use or disclosure: Donors, grant writers, social media platforms, non-profit organizations, educational and scientific programs, marketing projects, fundraising platforms, public in general, referring providers, government agencies, payors and any other third party.

Purpose of disclosure: Description of each purpose of the requested use or disclosure: for any purpose permitted under Internal Revenue Code section 501(c)(3) and state law; for education and scientific purposes; for fundraising and marketing purposes including social media and for any other lawful purpose.

This authorization is effective as of the date signed by the patient below and shall expire on _____ or no expiration if left blank (expiration date) or upon the occurrence of _____ or no event if left blank (insert description of event), whichever occurs first, unless sooner revoked by execution of the Revocation of Authorization below or other written form of revocation submitted by the patient or their personal representative. The patient understands that their revocation does not affect any use or disclosure that occurred prior to the revocation or to the extent that iTASC has acted in reliance on this Authorization. A photocopy, facsimile, pdf of this Authorization is as valid as the original.

Understanding and Acknowledgement

1. I understand that iTASC will not use or disclose my PHI except as described in this Authorization.
2. I understand that iTASC may not condition referral for treatment, enrollment, or eligibility for treatment on whether I sign this Authorization when the prohibition on placing such conditions applies.
3. I understand that I may revoke this Authorization at any time, provided that the revocation is in writing, and can do so by signing the Revocation section at the end of this Authorization or by submitting some other form of written document to iTASC revoking this Authorization, to: iTASC, 3025 Governors Place Blvd., Dayton, Ohio 45409 Attn: President.
4. I understand that if revoked, this Authorization will not affect any action, use or disclosure that took place before iTASC received the revocation and such actions, use or disclosure may include worldwide dissemination of my PHI.
5. I understand that the PHI to be used and disclosed pursuant to this Authorization is subject to redisclosure by the recipient and no longer protected.
6. I understand that I must be provided a copy of this signed Authorization.
7. I understand that this Authorization will not be valid if:
    a. The expiration date has passed, or the expiration event is known by iTASC to have occurred
    b. The Authorization has not been filled out completely
    c. The Authorization is known by iTASC to have been revoked
    d. Any material information in the Authorization is known by iTASC to be false in any material way
8. I understand that I may see and copy the information described on this Authorization if I ask for it in writing to: iTASC, 3025 Governors Place Blvd., Dayton, Ohio 45409 Attn: President.

____ I would prefer that my PHI not be used (initial if applicable).

_____ Date: _____

Patient signature

_____

Print name

Revocation of Authorization by Patient for Use and Disclosure of Protected Health Information

The undersigned patient (the "Patient") does hereby revoke this Patient Authorization for Use and Disclosure of PHI. The effective date of this revocation is the date received by iTASC. Please send this revocation to: iTASC, 3025 Governors Place Blvd., Dayton, Ohio 45409 Attn: President.

The undersigned patient understands that this revocation does not affect any use or disclosure that occurred prior to the revocation or to the extent that iTASC has taken action in reliance on this Authorization.

_____ Date: _____

Patient signature

_____

Print name