PATIENT INFORMATION RELEASE FORM

The CCA applicant is to fill out his/her name, supervising clinician information, case number, patient's name and contact information. Please provide this form to the patient for completion. The patient is to return the release form to the CCA applicant for submission as part of his/her Certified Clinical Anaplastologist (CCA) application process.

CCA Applicant Name: _____

Eligibility Application Case #: _____

Patient Name: _____

Patient Instructions

The Board for Certification in Clinical Anaplastology (BCCA) requests your authorization to release personal healthcare information (PHI) from your clinician to the BCCA solely for the purpose of considering his/her application for eligibility for the CCA credential. Please indicate whether or not you wish to participate by checking the appropriate box below. Once signed and completed, please return the form to the clinician at the address listed below.

Dear Patient,

As part of the requirements for certification in clinical anaplastology, applicants must submit case examples of their work. This requires the release of clinical photographs, and in some cases pertinent patient history, clinical diagnosis, rationale for treatment plans, and follow-up findings (referred to as 'protected healthcare information,' or PHI). This information is reviewed by the BCCA Credentials Committee for determining the eligibility of the applicant to sit for the certification examination. No PHI is to be identified with the patient's name, address, or contact information. The BCCA agrees to ensure your confidentiality, privacy and anonymity by not sharing this information with anyone outside the BCCA Board or staff, unless authorized by you in writing or otherwise required by law.

You may cancel this authorization at any time except to the extent already relied on and used for evaluation purposes prior to such cancellation. Your decision whether or not to participate is voluntary and should not affect the quality of care by your clinician.

I DO authorize the use of my PHI for the purposes defined above.

I understand that once released, the information will be held by the BCCA on a confidential basis and will be disposed of according to the BCCA's record and retention policies. I hereby release from any liability the BCCA, its Board members, employees, or agents and my clinician, his or her employees, or agents and their practice with regard to usages as agreed to herein.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

Supervising Clinician Name: _____

Degree/Credential: _____

Specialty Area: _____

Institution/Practice Name: _____

Address: _____

City/Province: _____

State: _____ Zip Code: _____

Contact Number: _____

Email: _____

Supervising Clinician Signature: _____

Board for Certification in Clinical Anaplastology (BCCA)
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Sykesville, MD 21784