HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 2024

I. THE PATIENT.
This form is for use when such authorization is required and complies with Accountability Act of 1996 (HIPAA) Privacy Standards.
Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

II. AUTHORIZATION.
I authorize _____ ("Authorized Party") to use or disclose the following: (check one)
☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____. Hereinafter known as the "Medical Records."

III. DISCLOSURE.
The Authorized Party has my authorization to disclose Medical Records ONLY to the following party:
Name: LIFE Scholarship Foundation, Inc. and its representatives
Address: P.O. Box 290078, Brooklyn, NY 11229
E-Mail: info@lifescholarshipfoundation.org

IV. PURPOSE.
The reason for this authorization is General Purpose – Scholarship Application/Verification of Medical Condition

V. TERMINATION. This authorization will terminate on the following date: 12/31/2024.

VI. ACKNOWLEDGMENT OF RIGHTS. I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____
Date: _____
Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)
The patient is unable to sign due to: (check one)
☐- Being a Minor. Patient is ____ years old and considered a minor under state law.
☐- Being Incapacitated. Patient is incapacitated due to: _____.
☐- Other: _____.

Signature of Representative: _____ Date: _____ Print Name: _____
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____