

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH

INFORMATION Date: \_\_\_\_\_

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: \_\_\_\_\_