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 the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name:
Date of Birth:
Social Security Number:

II. **AUTHORIZATION**. I authorize **The Ree Wynn Foundation** ("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: to: .
☐ - Other:

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.

☐ - ONLY the following party:
Name: The Ree Wynn Foundation
Address: PO Box 543,Pennsauken, NJ 08109
Phone:(856)438-0632
Fax:
E-Mail: Emergency-Support@reewynn.org

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with third parties for the purpose of providing emergency support.

☐ - **Other**:

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date:
☐ - Other:

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 might not be able to revoke this authorization if its purpose was to obtain insurance.

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 understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

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: