

Gold Ribbon Scholarship

Emily's Kids Foundation Inc.

HIPAA Release of information



AUTHORIZATION FORM

I, _____ hereby authorize _____ and its affiliates, its employees and agents (collectively), to release to Emily's Kids Foundation Inc. my personal health information. (e.g., information relating to the diagnosis, treatment, and health care services provided or to be provided to me and which identifies my name, address, social security number, dates of treatment) **except** the following information about me:

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY]. I understand that any personal health information or other information released to the organizations identified above may be subject to re-disclosure by such organizations and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below and shall expire the earlier if _____ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES]** or the date my care ends with _____. I understand that I have a right to revoke this authorization by providing written notice to _____ and Emily's Kids Foundation Inc. However, this authorization may not be revoked if _____ or Emily's Kids Foundation Inc, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand this will stop scholarship process.

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Applicant identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Applicant's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____