

Authorization For Use/Disclosure of Protected Health Information

TO: "Physician"

RE: _____ ("Patient")
_____ (Patient's Date of Birth)

I authorize the use and disclosure to the Starlight Children's Foundation of protected health information about the Patient, as described below.

1. Information that may be used/disclosed: All protected health information relating to the Physician's assessments of: (a) whether the Patient is medically eligible for Starlight Children's Foundation's services; and (b) if so, whether his/her desired wish is medically appropriate. In addition, the Physician is authorized to fill out, sign and provide to Starlight Children's Foundation any medical information that Starlight Children's Foundation may require.

2. Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives.

3. Persons authorized to receive the information: Employees or other authorized representatives of: Starlight Children's Foundation

4. Purpose for which information will be used/disclosed: To enable Starlight Children's Foundation to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to participate in programs offered by Starlight Children's Foundation and (b) pertinent information relating thereto.

5. Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

A. I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;

B. I understand that I may refuse to sign this authorization and that my refusal to do so will not affect Patient's ability to obtain treatment or payment or eligibility for benefits; and

C. I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Name of Patient's representative

Relationship to Patient

Signature of Patient's representative

Date