BRINGING HOPE HOME ADOPT-A-FAMILY GIFT APPLICATION

1 of 4) HIPAA Authorization Form – Healthcare Provider/Physician/Facility

I, _____, *(Name of Nominee Patient)* hereby authorize _____ *(Name of Healthcare Provider/Physician/Facility)* to release and furnish to Bringing Hope Home copies of full and complete protected medical information, including the following:

- For use in the Bringing Hope Home Adopt-A-Family Program (the "Program"). To my healthcare provider: This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.

- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports. All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology, cytology, histology, autopsy, immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____ *(Name of Healthcare Provider/Physician/Facility)*. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above. This authorization does not apply to psychotherapy notes, psychiatric or psychological records. **A notarized signature is not required.** 45 CFR 164.508. A facsimile or copy of this authorization shall have the same force as an original.

Unless earlier revoked, this authorization shall expire in its entirety upon Bringing Hope Home's determination that I am ineligible for the Program, or, if no such determination of ineligibility is made, upon Bringing Hope Home's final decision to grant or deny an award to me under the Program.

_____ _____

Signature of Nominee Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

Description of Personal Representative's Authority to Sign for Patient *(attach documents which show authority)*:

_____

This authorization is valid only for records from: _____

Name of Healthcare Provider/Physician/Facility

If there are any questions, please call Bringing Hope Home at 484-580-8395.

BRINGING HOPE HOME ADOPT-A-FAMILY GIFT APPLICATION

2 of 4) HIPAA Authorization Form – Nominator

I, _____, *(Name of Nominee Patient)* hereby authorize _____ (*the "Nominator*") to (i) review my health record and (ii) release and furnish to Bringing Hope Home certain protected medical information, including information regarding the diagnosis and treatment of me, solely for the purpose of completing the nomination forms for the Bringing Hope Home Adopt-A-Family Program (the "Program"). I understand that the Program nomination forms require disclosure of certain medical information, and I hereby authorize and consent to the inclusion of such information in the nomination forms.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____ *(name of nominator)*. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above. This authorization does not apply to psychotherapy notes, psychiatric or psychological records. **A notarized signature is <u>not</u> required.** 45 CFR 164.508. A facsimile or copy of this authorization shall have the same force as an original. Unless earlier revoked, this authorization shall expire in its entirety upon Bringing Hope Home's determination that I am ineligible for the Program, or, if no such determination of ineligibility is made, upon Bringing Hope Home's final decision to grant or deny an award to me under the Program.

_____ _____
Signature of Nominee Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

Description of Personal Representative's Authority to Sign for Patient *(attach documents which show authority)*:

_____

This authorization is valid only for information provided by: _____

Name of Nominator

[End of HIPAA Authorization Form]

3 of 4) Authorization Form – Personal Story

I, _____, *(Name of Nominee)* understand that (i) certain information about me, including but not limited to my age, diagnosis and a description of the effect that my diagnosis has had on me and my family (my "Personal Story"), will be shared with Bringing Hope Home ("BHH") in connection with the BHH Adopt-A-Family Application, (ii) if I am awarded assistance under the BHH Adopt-A-Family Program (the "Program"), BHH may wish to share my Personal Story or any part thereof (a) with the donor who supported the gift assistance made to me, and/or (b) with personnel working at or for BHH in order to facilitate the assistance and the benefits associated with it, including the delivery of gifts and other items to the family, and/or (c) on BHH's website and social media websites and applications, including Twitter, Facebook and Instagram ("Online Uses"), (iii) my Personal Story will **<u>not</u>** be shared through online platforms **<u>unless</u>** I select one of the options listed below and (iv) my eligibility for assistance under the Program will not be affected by my decision to select or not select any of the options listed below.

I hereby authorize BHH to share my Personal Story as follows:

☐ BHH may share my Personal Story, including my first name but not my last name, with third parties, including Online Uses.

☐ BHH may share my Personal Story, including my first name but not my last name, with third parties, excluding Online Uses.

_____
Signature of Nominee

_____ _____
Name of Nominee Date

If there are any questions, please call Bringing Hope Home at 484-580-8395.

BRINGING HOPE HOME ADOPT-A-FAMILY GIFT APPLICATION

4 of 4) Consent to Photograph, Videotape, Film and/or Interview

I authorize the taking and publication of photographs, movies, videotape or audiotape of me for the purpose of publicity to be used by Bringing Hope Home and _____ (*name of nominee*).

I agree to participate in Adopt-A-Family public information, education or advertising programs and activities (Programs). I also authorize public release of information I share about my medical treatment and myself during interviews related to my participating in the Programs, this includes but is not limited to interviews with news reporters and/or public relations staff.

I understand this means that my likeness and personal information may be used in newspapers, magazines, exhibits, educational video tapes, on the internet, on television or radio, or in Bringing Hope Home publications; that I may be identified by name or by likeness; and that, by implication, information pertaining to my health status may be disclosed by virtue of my participation in any given Program. Bringing Hope Home presenter publications include any publications by members and affiliates of Bringing Hope Home.

I understand that by providing my consent to participate in the Program described above and by signing this consent I am providing Bringing Hope Home with a valid authorization to disclose my Protected Health Information ("PHI") as defined in the health Information Portability and Accountability Act ("HIPAA").

In consideration for the opportunity to participate in the Programs, I release Bringing Hope Home and its members and affiliates, its officers, employees, trustees, medical staff, and agents from any and all liability arising from or relating to the publication, release or disclosure of my likeness, my identity and health-related information.

I waive my right to inspect or approve the photographs, movies, videotapes, audiotapes, advertising copy, news releases or printed material that may be used in conjunction with the photographs, movies, or audio/video tapes, or the eventual use to which they may be applied. I acknowledge that I will not receive any remuneration as a result of my participation in any given Program.

I have read the foregoing release, fully understand its contents and, by my signature, intend to be legally bound.

_____
Signature of Nominee (If subject is under 18 years of age, signature must be that of parent or legal guardian.)

_____ _____
Witness Date

- Staff Use -

Please print subject's name: _____

Address: _____

City/State/Zip Code: _____

Telephone number: _____

Photographer: _____ _____ ☐ B&W Prints ð Color Prints
☐ Video ☐ Audio ð Electronic file

Interviewer: _____

Purpose/Affiliate Name: _____

If there are any questions, please call Bringing Hope Home at 484-580-8395.