BRINGING HOPE HOME LIGHT OF HOPE FAMILY GRANT APPLICATION

1 of 3) 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 Light of Hope Family Grant Program (the "Grant 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 Grant 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 Grant 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 Director of Family Outreach Amy Forkin at 484-580-8395.

BRINGING HOPE HOME LIGHT OF HOPE FAMILY GRANT APPLICATION

2 of 3) 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 Light of Hope Family Grant Program (the "Grant Program"). I understand that the Grant 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 Grant 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 Grant 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 3) 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 Light of Hope Family Grant Application, (ii) if I am awarded a grant under the BHH Light of Hope Family Grant Program (the "Grant Program"), BHH may wish to share my Personal Story or any part thereof (a) with the donor who supported the grant made to me, and/or (b) 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 with any third party **<u>unless</u>** I select one of the options listed below and (iv) my eligibility for a grant under the Grant 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 (**please check one**):

- ☐ 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 but **<u>not</u>** my 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.
- ☐ BHH may not share my Personal Story or my name, with third parties

____
Signature of Nominee

____ ______________________
Name of Nominee Date

If there are any questions, please call Bringing Hope Home Director of Family Outreach Amy Forkin at 484-580-8395.