HIPAA AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION 2022

Please fill out and send to patient's physician to maintain in patient's file, or if physician has own form, please contact physician, fill out such form and have physician maintain in patient's file.

DO NOT SEND THIS FORM TO THE CAMP HOPE OFFICE!

Physician Name: _____

Patient's Full Legal Name: _____

Parent or Custodian's Full Legal Name (if applicable) : _____

Patient's Date of Birth: _____

Patient's Telephone: _____

Patient's Address: _____

The above patient is participating in Camp Hope, a program of Kidz2Leaders. Pursuant to the HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 164.512 & 164.508, I hereby authorize you to use or disclose the above-named patient's protected health information, as described below. I authorize the following individuals or organizations to receive such health information: Kidz2Leaders. The purpose of the requested use or disclosure is: for the purpose of providing medical information in a medical emergency, as determined in Kidz2Leaders' sole discretion. The information to be used or disclosed includes the following specified information: All Medical Records (including information related to my identity, diagnosis, prognosis and/or treatment, which may include substance abuse, mental health, sexually transmitted diseases, pregnancy, and/or HIV/AIDS information.) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. I authorize the release of such information, with the following exceptions:_____.
This authorization will expire at the end of the Camp Season. Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. I understand that I am waiving my right to privacy and this information may be disclosed by the recipient. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the healthcare provider releasing the information. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits. I understand that if this authorization is sought by a covered entity I will be given a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative (include relationship or nature of authority):

_____

Date: _____ *Relationship (if applicable):* _____