The Never Alone Foundation
Authorization for Use and Disclosure of Protected Health Information

Because your home study may contain medical information and the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects patients from the unauthorized use or disclosure of protected health information about them, we request that all applicants sign his Authorization which allows The Never Alone Foundation to use and disclose your protected health information according to the terms herein.

APPLICANT #1 NAME/DOB:____

APPLICANT #2 NAME/DOB:____

Address (including zip code):____

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I authorize the use and disclosure of my Protected Health Information according to the terms herein. I understand that only persons or entities having rights under this Authorization may use and disclose my Protected Health Information in accordance with this Authorization.

A. *Persons authorized to disclose and receive Protected Health Information: I authorize any physician, physician practice group, dentist, hospital, nurse, medical laboratory, health plan and any other health care provider, health insurance issuer or agent, affiliate, or broker of any of the aforementioned (collectively "Providers") possessing any past, current, or future medical records, including, but not limited to, physical or mental health information, (collectively "Protected Health Information") to disclose to The Never Alone Foundation (NAF), its agents, affiliates, independent contractors, service providers or other representatives (collectively "Recipient") any and all such Protected Health Information as requested by NAF. This Authorization permits and authorizes the disclosure, inspection, and copying of any and all records, reports and/or documents that contain my Protected Health Information, including, but not limited to, any and all medical charts, clinical or doctors' notes (excluding psychotherapy notes), memoranda, radiology, pathology, or test reports, index cards, history notes, mental health records, pictures, patient management records, claims records, payment for the provision of healthcare and medical bills.*

B. *Purpose of this Authorization: I understand that the information obtained pursuant to this Authorization will be used by Recipient to determine whether to approve my grant application. Except as permitted by this Authorization, no Recipient will release any information obtained pursuant to this Authorization to any person or*

organization except: (1) pursuant to this Authorization, or (2) as may otherwise be lawfully required, or (3) as I may further authorize.

C. *Expiration: I agree that this Authorization shall remain valid and enforceable for one year from the date of execution or until this Authorization is completely revoked by me, unless earlier terminated by applicable law. I understand that I may partially revoke this Authorization with respect to particular Recipients and this will not affect any other Recipient's rights hereunder.*

D. *Voluntariness of the Authorization: I understand that my signature and approval of this Authorization and its contents is voluntary, however I understand that Recipient will not be able to properly administer my grant application without my signature and disclosures. I further understand that I will not be denied any medical treatment for my failure to sign this Authorization. Revocation of this Authorization must be made in writing to NAF and shall be effective immediately upon NAF's receipt of my revocation. However, revocation does not terminate any Recipient's ability to use my Protected Health Information already collected and will not be effective to the extent that a third party has taken action in reliance on this Authorization for a use or disclosure of my Protected Health Information prior to receiving my revocation.*

E. *Reuse and Re-disclosure: I understand that disclosure of Protected Health Information to a Recipient pursuant to this Authorization may result in the disclosure of my Protected Health Information to third parties who are not covered by state or federal privacy law. In this case, I understand that my Protected Health Information may not be protected by the HIPAA Privacy Regulations and as a result may be subject to redisclosure by the Recipient and furthermore is no longer protected by federal or state privacy laws.*

BY SIGNING THIS AUTHORIZATION FOR RELEASE OF MY PROTECTED HEALTH INFORMATION, I UNDERSTAND AND AGREE TO THE STATEMENTS CONTAINED HEREIN AND AUTHORIZE THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED HEREIN.

____
Applicant #1 Signature

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Date

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Applicant #2 Signature

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Date