3 LITTLE BIRDS 4 LIFE
PO Box 187 - Collinsville, IL 62234

HIPAA FORM

Authorization for Use/Disclosure of Protected Health Information

TO: _____ _____ _____
(Physician) (Physician's Address) (Physician's Telephone Number)

RE: _____ _____
(Patient - Print Name Legibly) (Patient's Date of Birth)

I authorize the use and disclosure to 3 Little Birds 4 Life of protected health information about Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessments of:

(a) whether Patient is medically eligible for 3 Little Birds 4 Life services;
(b) if so, whether his/her desired wish is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to 3 Little Birds 4 Life forms that 3 Little Birds 4 Life may require, including forms relating to Patient's medical eligibility, the requested wish and medical considerations relating thereto.

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

Persons authorized to receive the information: Employees or other authorized representatives of:
3 Little Birds 4 Life - PO Box 187, Collinsville, IL 62234 - 618-977-0519 (phone) - ashley@3littlebirds4life.org

Purpose for which information will be used/disclosed: To enable 3 Little Birds 4 Life to obtain:

(a) physician's assessments regarding whether Patient is medically eligible to have a wish granted by 3 Little Birds 4 Life, and, if so, whether the requested wish is medically appropriate; and
(b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's Wish has been granted by 3 Little Birds 4 Life or a final determination has been made that Patient is not eligible to receive a wish.

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 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.

_____ _____ _____
Patient Name Patient Signature Date