MEMORIES for kids

Creating lifelong memories for children who have a parent with stage IV cancer.

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 Memories for Kids 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 Memory Foundation services; and

(b) if so, whether his/her desired wish is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to Memories for Kids forms that Memories for Kids 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: Board Members or other authorized representatives of: Memories for Kids, P.O. Box 540216, Omaha, NE 68154, (402) 889-5797, memoriesforkids.org

Purpose for which information will be used/disclosed: To enable Memories for Kids to obtain:

(a) physician's assessments regarding whether Patient is medically eligible to have a memory granted by Memories For Kids 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 memory has been granted by Memories for Kids or a final determination has been made that Patient is not eligible to fulfill a memory.

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.

Please enter full name in the Patient Name line below to accept the policy.

☐ **I understand that by typing my name and submitting this document, I am electronically signing this document.**

Patient Name: _____ Patient Signature: _____ Date: _____

Patient Representative: _____ Patient Representative Signature: _____ Date: _____