HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Facility authorized to disclose protected health information: _____ ("Health Care Provider')

I have applied for a grant from Heaven's Cradle, Inc.

This form authorizes the release and/or disclosure of my protected health information and medical information to Recipient (hereinafter defined). Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, 45 CFR § 164.08, the below-identified Patient hereby authorizes the release and disclosure of protected health information to

Heaven's Cradle, Inc., its directors or employees (collectively, the "Recipient").

Patient Name: _____

I also authorize you to speak to the Recipient regarding the medical information of Patient.

The purpose of this Authorization is to obtain information that may be used to confirm Patient is eligible for a grant.

This Authorization will expire on _____ (Authorization Date"). This request is continuing in nature until the Expiration Date or my written revocation of this Authorization.

I understand that:

• I am not required to sign this Authorization.
• The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
• I may revoke this Authorization at any time prior to the Expiration Date, but my revocation will not have any affect on actions taken before my revocation. Should I desire to revoke this Authorization, I must send written notice to the Recipient and the Health Care Provider.
• There is a prohibition against conditioning treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
• The Health Information may be subject to disclosure by the Recipient and may no longer be protected by federal privacy regulations.

I hereby affirm that I have received a copy of this Authorization.

An electronic copy of this Authorization shall be as valid as the original.

I, the undersigned and above-identified Patient, hereby authorizes the release of medical information to Recipient.

_____
SIGNATURE OF PATIENT

_____
DATE*