Your Story Foundation Medical Authorization and Release

PHYSICIAN:

PHYSICIAN ADDRESS:

THE UNDERSIGNED, for legal purposes pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Section 164.508 of the final Privacy Rule, RCW 70.02, and applicable regulations issued thereunder, authorizes the release and disclosure by any insurance company, health care provider, clinic, hospital, physician, nurse, pharmacist, or a duly authorized representative of the same, of all protected health care information, including medical records and information concerning all aspects of care or treatment rendered (except sensitive health care information protected by 42 CFR, Part II (substance use disorder) or RCW 70.24 (control and treatment of sexually transmitted disease)) to any representative of Your Story Foundation, a Washington non-profit corporation, 1202 12th St. Anacortes, WA. 98221

The information released will be used to enable Your Story Foundation to determine eligibility for a charitable grant; and to further this purpose and in fulfillment of such grant application, the undersigned authorizes his/her primary physician and/or oncologist to provide, upon reasonable request, Your Story Foundation additional information relating to the undersigned's medical eligibility and medical needs.

The undersigned, individually, and on behalf of his/her heirs, representatives and assigns, shall forever release, indemnify, and hold harmless Your Story Foundation for any and all claims, demands or causes of action for any injury or damages arising out of any disclosures of protected medical information pursuant to the grant application process and pursuant to this Medical Authorization and Release.

In compliance with HIPAA and Section 164.508 of the final Privacy Rule, the undersigned acknowledges:

- I do not have to sign this authorization and release in order to obtain health care benefits (treatment, payment or enrollment).
- I may revoke this authorization in writing at any time, and such revocation shall be effective as of the date such written notice is received by the above-named provider or Your Story Foundation.
- I understand and acknowledge that if the person or entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations (such as Your Story Foundation), that such information will no longer be protected by regulations and privacy rules of 45 CFR § 164 and could be disclosed or re-disclosed by such recipient.
- A photostatic, digital or electronic copy of this document shall be as valid as the original.
- This authorization expires ninety (90) days from the date signed.

Date:

Signature:

Printed Name:

Date of Birth: