

**AUTHORIZATION FOR USE OR RELEASE OF  
HEALTH INFORMATION**

I hereby voluntarily authorize the use of or release of my health information to [Name of Entity] to permit [Name of entity ] to use or disclose the identified health information in connection with or in furtherance of the [name] fund raising efforts, as follows:

*(Please print clearly and complete all parts of this form. If you do not fill in the form completely, your request will not be processed and the incomplete authorization will be returned to you.)*

**I. Individual Information**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**II. Identification of Person or Organization Receiving Information**

My health information may be disclosed to the following person(s) or organization(s):  
*(attach more sheets if necessary)*

Name: [Name of foundation]  
Attention: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

**III. Purpose(s) for the Release or Disclosure of Information**

At my request  
Other *(please specify)*: For the purpose of raising funds, or soliciting funds, or targeting the solicitation of funds, for and in furtherance of the activities of  
[Insert name of supported  
entity] \_\_\_\_\_

**IV. Description of Information to be Released or Disclosed *(check all appropriate)***

Patient records  
Diagnosis and treatment received while a patient at the [insert name ]  
Other *(please specify)*: \_\_\_\_\_

Exclusions (*please specify*): I request that the following information not be used or disclosed in connection with the fund raising efforts described above:

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**V. Other Important Information**

*Your signature below means that you understand and agree to the following:*

The health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS), and/or genetic marker information. These records may be included in the information we will make available to the individual or organization you have identified above.

The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed by the recipient and no longer protected by federal privacy regulations.

You must sign this form in order for your request to release the information described above to be honored.

You may receive a copy of this form if you ask for it by writing to the provider.

This authorization will expire two years from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying, in writing, the provider who is disclosing the information. Revoking this authorization will not have any effect on actions taken in reliance on the authorization before notice is received of your revocation.

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**VI. Signature of Individual or Individual's Representative**

\_\_\_\_\_  
Signature of Individual or representative

\_\_\_\_\_  
Date

If this authorization is signed by an individual's representative, the following additional information must be provided:

\_\_\_\_\_  
Name of personal representative (please print)

\_\_\_\_\_  
Relationship to the individual, including authority for status as representative

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