Authorization for Release of Medical Records

Authorization for Use and Disclosure of Protected Health Information Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This form gives your health care providers written authorization to release your health information to the persons named in section 2.

NAME OF CLAIMANT

First Name	MI	Last Name

Date of Birth	Social Security lumber
/ /	- --

1. I hereby authorize all medical service sources and health care providers to disclose the protected health information (''PHI'') described below to the Fund Administrators and their agents of Indianapolis 4/15 Survivors Fund.

2. I hereby authorize the release of my PHI from my healthcare providers to be used solely by Indianapolis 4/15 Survivors Fund Administrators to facilitate confirmation of the hospitalization dates and the nature of the physical or psychological injury(ies) sustained by me as a result of the shooting on April 15, 2021.

   The following specific entity may receive disclosures of protected health information about me:

   Fund Administrator
   Indianapolis 4/15 Survivors Fund
   c/o National Compassion
   Fund 1450 Duke St
   Alexandria, VA22314

   Or its agent:
   Hogan-Lovells US LLP
   555 Thirteenth Street, NW
   Washington, DC 20004

3. This authorization of the release of my PHI covers the period: <from April 15, 2021 to December 31, 2021

4. This authorization shall be in force and in effect until December 31, 2021, at which time this authorization expires.

5. I understand that this authorization is voluntary and that I have the right to revoke this authorization, in writing, at any time by notifying the Fund Administrator at the address shown above, or by contacting my health care providers individually. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand information released pursuant to this authorization may no longer be protected by HIPAA privacy regulations and may be subject to re-disclosure according to the rules governing the National Compassion Fund.

6. I understand this authorization may be necessary as a condition of obtaining compensation from Indianapolis 4/15 Survivors Fund, but other treatment, payment, enrollment or eligibility for benefits is not conditioned on whether I sign this authorization.

_____

Signature (*if the Victim is under 18, the line above must be signed by a parent or a guardian*)

_____

Date

Si necesita ayuda para llenar este formulario, por favor llame al Centro de Recursos para Víctimas (VictimConnect Resource Center) al 855-4-VICTIM (855-484-2846) o envíe un mensaje electrónico a *Indy@NationalCompassionFund.org*