Authorization for Release of Medical Information

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 Number
/ /	- -

1. Pursuant to s. 456.057(a), Fla. Stat., and the requirements of HIPAA Sections 164.512 & 164.508, I am authorizing you, as one of my health care practitioners or providers, to advise I hereby authorize all medical service sources and health care providers to disclose the protected health information (“PHI”) described below to the Fund Administrators of Support Surfside Fund, their agents, and the Miami-Dade County State Attorney’s Office whether you examined and/or treated me on or about June 24, 2021 as a result of the Champlain Towers South collapse in Surfside, Florida.

2. I hereby authorize the release of my PHI from my healthcare providers to be used solely by Support Surfside Fund Administrators and the Miami-Dade County State Attorney’s Office to facilitate confirmation of the hospitalization dates and the nature of the physical injury(ies) sustained by me on or about June 24, 2021 as a result of the Champlain Towers South collapse in Surfside, Florida.

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

   Fund Administrator
   Support Surfside Fund
   c/o National Compassion Fund
   1450 Duke St
   Alexandria, VA 22314

   Or its agent:
   Wiley-Rein LLP
   1776 K St NW,
   Washington, DC 20006

   Or Miami-Dade County State Attorney’s Office

3. This authorization of the release of my PHI covers the period from June 24, 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 Support Surfside 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

STATE OF FLORIDA, COUNTY OF MIAMI-DADE:

Sworn to (or affirmed) and subscribed before me by means of ☐ physical appearance or ☐ online notarization this _____ day of _____, _____, by _____.

_____

NOTARY PUBLIC, STATE OF FLORIDA

☐ Personally Known _____

☐ Produced Identification, type: _____

_____

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 *Surfside@NationalCompassion.org*