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)

PLEASE NOTE THAT THIS FORM MUST BE CO-SIGNED BY A WITNESS

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

CLAIMANT Information		
First Name	**MI**	**Last Name**
Date of Birth		**Last 4 digits of SSN**
/ /		

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 the Oxford Survivors' Fund, National Compassion Fund.

2. I hereby authorize the release of my PHI from my healthcare providers to be used solely by the Oxford Survivors' Fund.

3. I authorize only the release of information confirming my treatment for gunshot wound(s) as a result of the shootings on November 30, 2021, and the dates of my treatment / hospitalization.

4. I do not authorize the release of Behavioral and Mental Health Service Information, referrals and treatment for alcohol and substance use disorder, Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

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

   Fund Administrator
   c/o National Compassion Fund
   1450 Duke St Alexandria, VA22314

   Or its agent:
   Hogan-Lovells LLP

6. This authorization of the release of my PHI covers the period: from November 30, 2021 to June 15, 2022.

7. This authorization shall be in force and in effect until July 1, 2022, at which time this authorization expires.

8. 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.

9. I understand this authorization may be necessary as a condition of obtaining compensation from the Oxford Survivors' Fund, but other treatment, payment, enrollment or eligibility for benefits is not conditioned on whether I sign this authorization

Signature of patient: ______________________________ Date: ____________________
(If patient either is under legal age of has a guardian appointed by the court, this release must be signed by the patient's parent or guardian.)

Signature of Parent/Guardian: ______________________________ Date: ____________________

Printed Name of Parent/Guardian: ___________________________________

Relationship to Patient: ____

Signature of Witness____ Date:________________________________

Si necesita ayuda para llenar este formulario, por favor envíe un mensaje electrónico a Oxford@NationalCompassion.org