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 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 Buffalo 5/14 Survivors Fund, National Compassion Fund.

2. I hereby authorize the release of my PHI from my healthcare providers at [Name of Medical Provider]____, to be used solely by the Buffalo 5/14 Survivors Fund.

3. I authorize only the release of information confirming my treatment for injuries as a result of the shootings on May 14, 2022, 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:
   Venable, LLP

6. This authorization of the release of my PHI covers the period: from May 14, 2022 to December 31, 2022.

7. This authorization shall be in force and in effect until March 1, 2023, 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 Buffalo 5/14 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: _______________________________

[Type here]

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