Authorization for Release of Protected Health 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 healthcare providers written authorization to release certain health information, as designated below, 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 limited protected health information (''PHI'') described below to the Fund Administrators and their agents of the Covenant School Survivors Fund, National Compassion Fund for the purpose of consideration for obtaining a financial gift from the Love for Louisville Old National Bank Survivors Fund.

2. I hereby authorize the release of my PHI, as designated below, from my healthcare providers to the specific entities listed in (5) below, to be used solely by the Covenant School Survivors Fund authorized representatives.

3. **I authorize only the release of my protected health information confirming my treatment for injuries arising from the shootings on May 27, 2023, 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 entities may receive disclosures of protected health information about me:

   Fund Administrator
   c/o National Compassion Fund
   1450 Duke St Alexandria, VA 22314
   Nashville@NationalCompassion.org

   Or its agent:
   Hogan-Lovells LLP

6. This authorization of the release of my PHI covers the period: from March 27, 2023, to August 15, 2023.

7. This authorization shall be in force and in effect until October 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 by the recipient.

9. I understand treatment, payment, enrollment or eligibility for benefits by my healthcare providers 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 authorization must be signed by the patient's parent or guardian.)

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Parent/Guardian: _____

Relationship to Patient: _____

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