AUTISM STRONG FOUNDATION

# HIPAA RELEASE AND AUTHORIZATION

I, _____, hereby authorize the following persons (hereinafter collectively referred to as "agent") to act as my agents with regard to the matters specified in this Release:

Name: Becky Thoms & Stephanie Neuman
Organization: Autism Strong Foundation
Address: 9935D Rea Road #253, Charlotte, NC 28277

This Release and all the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Sections 1320d to 1320d-9 and 45 C.F.R. Sections 164.500 to 164.534, as may be amended from time to time.

## AUTHORIZATION

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose, and release to my agent who is named herein and who is currently serving as such and without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition. Additionally, this disclosure shall include the ability to ask questions and discuss this protected health information with the person or entity who has possession of the protected health information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to access any protected health information to my agent. Health information and medical records as indicated above shall be released at my request or at the request of my agent named herein as may be needed to assist in my treatment, make decisions about my care, or for any other reason, at my discretion or at the discretion of my agent.

The authority given to my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to re-disclosure by my agent and may no longer be protected by HIPAA.

## TERMINATION

This Release shall terminate on the first to occur of: (i) two years following my death, or (ii) my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other means evidencing actual receipt by the covered entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

## RELEASE FROM LIABILITY

Each covered entity that acts in reliance on this Release shall be released from liability that may result from disclosing my individually identifiable health information and other medical records.

## LEGAL ACTION

I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this Release. No covered entity may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 C.F.R. Section 164.508(b)(4) applies. Further, to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate to secure the disclosure of my individually identifiable health information and other medical records.

## SUBSEQUENT DISCLOSURE OF INFORMATION

Any information disclosed to my agent under this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act if information is subsequently disclosed by my agent.

## COPIES AND FACSIMILES

Copies or facsimiles of this Release shall be as valid as the original Release.

## SIGNATURE

Signature: Date:

Print your name:

If this Release is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this Release:

Signature of person completing this Release:

Describe below how this person has legal authority to sign this Release: