MEMORIES OF LOVE HIPAA FORM

Authorization for Use/Disclosure of Protected Health Information

TO: _____

(Physician)

_____

(Physician's Address)

_____

(Physician's Telephone Number)

RE: _____

(Patient - Print Name Legibly)

_____

(Patient's Date of Birth)

I authorize the use and disclosure to Memories of Love of protected health information about Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessments of: (a) whether Patient is medically eligible for Memories of Love services; and (b) if so, whether his/her desired wish is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to Memories of Love forms that Memories of Love may require, including forms relating to Patient's medical eligibility, the requested wish and medical considerations relating thereto.

Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives.

Persons authorized to receive the information: Employees or other authorized representatives of:

MEMORIES OF LOVE 4932 SUNBEAM RD., SUITE # 200, JACKSONVILLE, FL 32257
PHONE- 904-596-2789 FAX- 904-636-7780

Purpose for which information will be used/disclosed: To enable Memories of Love to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a wish granted by Memories of Love and, if so, whether the requested wish is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's wish has been granted by Memories of Love or a final determination has been made that Patient is not eligible to receive a wish.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

a. I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;

b. I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Patient Representative	Patient Representative Signature	Date